HEALTH INSURANCE FOR THE UNEMPLOYED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

MARCH 21, 1991

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HEALTH INSURANCE FOR THE UNEMPLOYED

THURSDAY, MARCH 21, 1991

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 9:34 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, MARCH 13, 1991

PRESS RELEASE #5
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance for the unemployed. The hearing will be held on Thursday, March 21, 1991, beginning at 9:30 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "The economy is sliding into a recession that will put two million Americans out of work. These workers, and their dependants, have lost not only their income, but often also their health insurance. In the case of illness, they face complete and total financial ruin."

The hearing will include consideration of a bill, to be introduced prior to the hearing, providing health insurance for individuals receiving extended unemployment benefits. The provisions in this bill will be similar to the health insurance benefits included in H.R. 5479, "The Economic Adjustment Assistance Act," introduced by Mr. Stark and Mr. Downey (D., N.Y.) during the 101st Congress. This bill provided that certain unemployed persons would receive benefits under the Medicare program.

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The unemployment rate was 5.3 percent in the first half of 1990, and is expected to increase to a peak of 6.9 percent in 1991. This implies that, at the peak, an additional 2.0 million people will be unemployed in 1991. As many as 20 million people are likely to experience some period of unemployment during the year.

Half of the unemployed are persons who are first time workers, are re-entering the labor force, or have voluntarily left their last job. The other half are unemployed due to job loss and, generally, are eligible for unemployment insurance benefits. Approximately 2.5 million persons will exhaust their unemployment compensation benefits; most of these will be unemployed for more than six months.

About two-thirds of the persons who are unemployed due to job loss retain some form of health insurance. They may have extended coverage from their union or prior employer, obtain coverage through their spouse's employer, or purchase continuation coverage from their prior employer under the so-called COBRA continuation coverage provisions included in the Consolidated Omnibus Budget Reconciliation Act of 1985.

In some cases, such as under the COBRA provisions, health insurance coverage may be available but at a relatively high cost. The estimated average cost of COBRA coverage for a family in 1991 is $400 per month while the average unemployment compensation benefit is only $730 per month.

The probability that an unemployed person will have some form of health insurance declines as the period of unemployment lengthens. Thus, the long-term unemployed are less likely to have health insurance than the short-term unemployed.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, April 1, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning. Today's hearing of the Health Subcommittee of the Ways and Means Committee will examine the issue of providing health insurance for workers who have lost their jobs and, as a result, their health insurance.

Since last year the economy has been sliding and the unemployment rate has risen. It is estimated there is an additional 2 million people who will be unemployed and as many as 20 million are likely to experience some period of unemployment and, therefore, lack of insurance during the year. The increasing numbers of the unemployed will obviously increase the number of uninsured. The CBO has estimated that we will have an additional 1 million people added to the rolls of the uninsured.

As we will hear today, the recession is placing additional strains on our health care system. Public hospitals and community health centers are seeing increases in their patient loads. So while we as a society may be caring for the uninsured, we are arguably giving them coverage too little too late.

Many of the short-term unemployed retain some type of health coverage through their spouse's employment or through special separation benefits. However, the long-term unemployed are less likely to have any form of insurance.

With my colleague, Mr. Coyne, I have introduced a bill this week, the Health Insurance for the Unemployed Act of 1991, that would make Medicare benefits available to the long-term unemployed.

Under this bill, individuals who qualify for extended unemployment benefits would also be entitled to enroll in the Medicare program. Enrollment would be either on an individual or family basis. A modest premium equivalent to the Part B monthly premium would be deducted from the worker's unemployment check.

It is important to recognize that the Medicare program offers the most efficient and cost-effective program for providing these important health insurance benefits.

With the annual real increase in national health care expenditures from 1985 through 1988 in the private sector running at 4.3 percent, Medicare's real costs have increased only by 3 percent. While there may, indeed, have been some cost shifting related to that increase, in the short term Medicare still remains the most efficient means of providing these benefits.

Under current law, very few individuals are able to qualify for extended unemployment compensation benefits. Thus, relatively few people would qualify for the health benefits proposed in this bill. However, Mr. Downey has introduced a bill, H.R. 1367, the Unemployment Insurance Reform Act, that would expand the pool of workers who would be eligible for these compensation benefits. This has been taken into account in the cost estimates that we have used.

I hope the bill I introduced will be considered in the context of the expanded availability of the long-term employment benefits.

While this bill was drafted without financing necessary to cover its costs, it is the Chair's intention that these benefits, if adopted, would be financed on a required pay-as-you-go basis.

I would like to thank the witnesses who are testifying today for their contributions to this hearing, and I would like at this point to recognize Mr. Gradison. We have then some other members of the committee who would like to make statements for the record. Mr. Gradison.

[The Chairman's opening statement follows:]

OPENING STATEMENT OF THE HONORABLE PETE STARK

Good morning.

Today's hearing will examine the issue of providing health insurance for workers who have lost their jobs and, as a result, their health insurance.

Since the summer of last year, the U.S. economy has been sliding into a recession. The unemployment rate has risen from 5.3% last year, and is projected to increase to a peak of 6.9% in 1991. This means that an additional two million people will be unemployed. As many as 20 million people are likely to experience some period of unemployment during the year.

Many of these workers, and their families, are losing not only their income, but also their health insurance. In the case of an illness, they face complete and total financial ruin.

Increasing numbers of unemployed will swell the ranks of the uninsured—people without health insurance. The Congressional Budget Office has estimated that the recession will add 1 million people to the rolls of the uninsured.

As we will hear today, the recession is already placing intolerable strains on our health care system. Public hospitals, community health centers, and emergency room physicians, the providers that typically bear the burden of caring for the poor and uninsured, are already seeing increases in their patient loads.

Resources that are only minimally adequate are being stretched to the limit.

Provisions in current law, known as the COBRA continuation requirements, allow people who have lost their jobs to purchase health insurance coverage from their prior employer. However, the availability of this coverage offers little consolation to the long-term unemployed during a recession.

The average monthly cost of family coverage under COBRA can exceed an estimated $400 per month, while the average monthly unemployment compensation check is only $730.

A family may be willing to commit to this expense when the prospects for re-employment are good. During a recession, families are more likely to forgo this coverage, save their resources, and simply hope to stay healthy.

As we will hear today, it is also true that many of the short-term unemployed retain some type of health coverage, usually through their spouse's employment, or through special separation benefits from their prior employer or union.

However, the long-term unemployed are less likely to have any form of health insurance than the short-term unemployed.

With my colleague Mr. Coyne (D., Pa.), I introduced a bill this week, H.R. 1492, the Health Insurance for the Unemployed Act of 1991, that would make Medicare benefits available to the long term unemployed.

Under this bill, individuals who qualify for extended unemployment compensation benefits would also be entitled to enroll in the Medicare program. Enrollment could be on either on individual or family basis. A modest premium, equivalent to the Part B monthly premium, would be deducted from the worker's unemployment check.

It is important to recognize that the Medicare program offers the most efficient and cost-effective program for providing these important health insurance benefits.

While the annual real increase in national health care expenditures from 1985 through 1988 in the private sector was 4.3%, Medicare's real costs increased only 2.9%.

Medicare also has an efficient administrative structure. Only 2.5% of Medicare's total costs are for administrative expenses. Large private insurers typically spend between 10 and 15% of their costs on administration.

Under current law, very few individuals are able to qualify for extended unemployment compensation benefits. Thus, relatively few people would qualify for the health benefits proposed in this bill.

Mr. Downey, (D., N.Y.) has introduced a bill (H.R. 1367, the Unemployment Insurance Reform Act of 1991) that would expand the pool of workers who would be eligible for extended unemployment compensation benefits.

I hope that the bill I introduced will be considered in the context of this expanded availability of long-term unemployment benefits.

While this bill was drafted without the financing necessary to cover its costs, I fully intend that these benefits, if adopted, would be fully financed on the required pay-as-you-go basis.

I would like to thank the witnesses who are testifying today for their contributions to this hearing. The problems created by a recession are complex, and I would like to assure the witnesses that their comments will help the Subcommittee to determine what actions may be appropriate.

Mr. **GRADISON**. Thank you, Mr. Chairman.

This hearing today is related to two important topics: the current recession and the status of health insurance coverage for the unemployed. Both issues are of vital concern to Congress and to the Nation.

However, Mr. Chairman, I am troubled by the apparent assumption underlying the bill H.R. 1492, also being discussed at this hearing, that certain unemployed Americans should be covered by Medicare. Last August at a joint hearing of the Human Resources and Health Subcommittees, I believe it was made abundantly clear that expanding Medicare coverage to specified unemployed groups, such as identified in H.R. 1492, may be both impractical and unadministrable.

Beyond implementation issues, Mr. Chairman, I also have grave concerns about piecemeal expansion of Medicare. Why should those on extended unemployment be singled out for Medicare? What about the groups which would not be added? What effects will such an expansion have on the fiscal health of the Medicare program, which is already facing bankruptcy—at least the hospital insurance program is facing bankruptcy early in the next century? And how are we going to pay for this expansion?

Further, considering the briefing by Dr. Reischauer of CBO, which this subcommittee received last week, I am somewhat confused about the direction and purpose of this hearing. Dr. Reischauer made two essential points. First, he cited the CBO and other projections for the economy which indicate the recession will be shallow. I hope he is right about that. Second, he presented a CBO analysis which indicates the recession is likely to increase unemployment by 2 million, but that a million laid-off workers and dependents will continue to have health insurance coverage during the downturn.

One can hardly be sanguine about this estimate. It is a serious matter when a million people become uninsured. However, we know very little about how long they will be uninsured or whether or not H.R. 1492 will have much effect on them. And, in the broader context of the uninsured problem, covering a million new uninsured barely scratches the surface of the 33 million Americans who lack health coverage.

Mr. Chairman, I share the deep concern I know you feel for uninsured Americans, but I also feel very strongly that the issue of the uninsured cannot effectively be dealt with in the Medicare context, and that piecemeal expansions of Medicare are not the way to go.

Mr. Chairman, in order to put today's discussion in a proper context, I ask unanimous consent that a copy of the materials Mr. Reischauer distributed at the subcommittee meeting of about a week ago be included in the record of this hearing.

Chairman **Stark**. Without objection, those comments will be made part of the record.

[The material referred to follows:]

Materials for Briefing by
Robert D. Reischauer
Director
Congressional Budget Office

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

The Effect of the Recession on the Number of People Without Health Insurance

March 13, 1991

TABLE 1. MEDIUM-TERM ECONOMIC PROJECTIONS FOR CALENDAR YEARS 1993 THROUGH 1996

	Estimated	Forecast		Projected			
	1990	1991	1992	1993	1994	1995	1996
Nominal GNP (Billions of dollars)	5,467	5,700	6,107	6,505	6,919	7,358	7,824
Nominal GNP (Percentage change)	5.1	4.3	7.1	6.5	6.4	6.3	6.3
Real GNP (Percentage change)	0.9	0.0	3.3	2.9	2.8	2.7	2.7
Implicit GNP Deflator (Percentage change)	4.2	4.3	3.7	3.5	3.5	3.5	3.5
Fixed-Weighted GNP Price Index (Percentage change)	4.6	4.6	3.8	3.8	3.8	3.8	3.8
CPI-U (Percentage change)	5.4	4.9	3.5	3.6	3.6	3.6	3.6
Unemployment Rate (Percent)	5.5	6.8	6.4	6.2	6.0	5.8	5.6
Three-Month Treasury Bill Rate (Percent)	7.5	6.6	7.0	6.7	6.3	5.9	5.7
Ten-Year Treasury Note Rate (Percent)	8.6	7.9	7.7	7.6	7.4	7.3	7.2
Tax Bases (Percentage of GNP)							
Corporate profits	5.5	5.2	5.7	5.5	5.2	5.0	4.9
Other taxable income	22.2	22.3	22.1	22.1	22.0	21.8	21.7
Wage and salary disbursements	49.4	49.4	49.4	49.5	49.6	49.8	49.8
Total	77.2	76.8	77.1	77.1	76.8	76.6	76.4

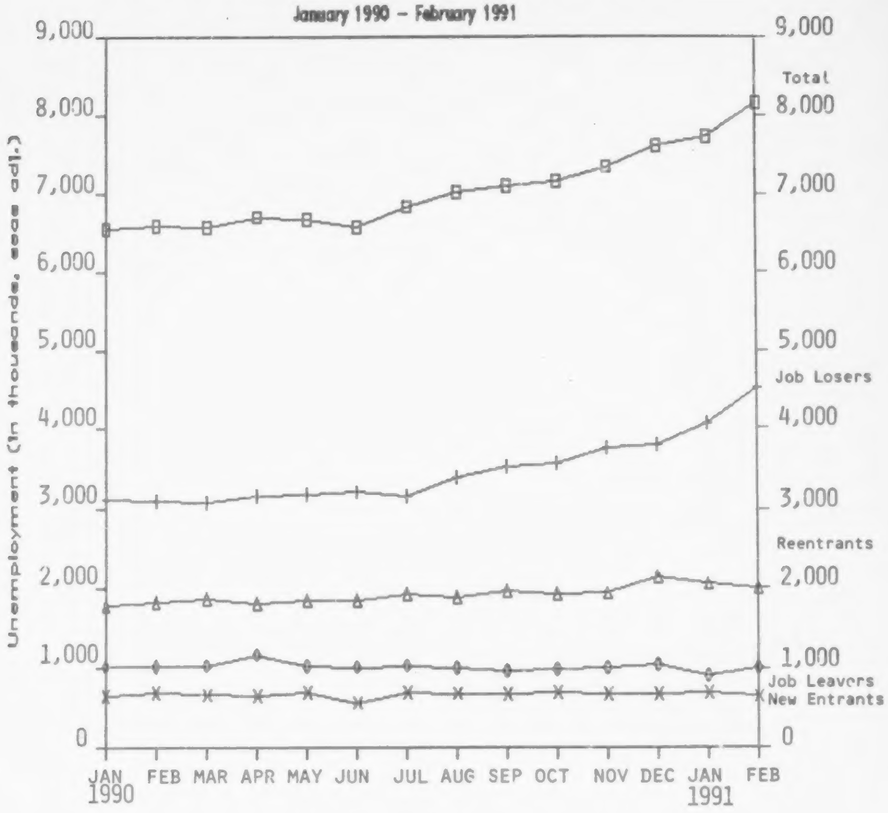
SOURCE: Congressional Budget Office.

NOTE: CPI-U is the consumer price index for all urban consumers.

FIGURE 1

Unemployment, By Reason,

January 1990 – February 1991



MONTH

SOURCE: CONGRESSIONAL BUDGET OFFICE, BASED ON DATA FROM THE BUREAU OF LABOR STATISTICS.

TABLE 2. THE GROWTH IN UNEMPLOYMENT SINCE JUNE 1990 (levels in thousands, seasonally adjusted)

Group	June 1990	February 1991	Change	
			Level	Percent of Total
Total, 16 years and over	6,560	8,158	1,598	100
Industry [a]				
Goods-producing	1,786	2,602	816	51
Mining	29	49	20	1
Construction	616	948	332	21
Manufacturing	1,141	1,605	464	29
Service-producing	3,231	3,835	604	38
Transportation and public utilities	202	349	147	9
Wholesale and retail trade	1,468	1,772	304	19
Finance and service	1,561	1,715	154	10
Government workers	524	594	70	4
Agricultural	183	212	29	2
Demographic Characteristics				
Men, 20 years and over	3,048	4,044	996	62
Women, 20 years and over	2,432	2,881	449	28
Both sexes, 16 to 19 years	1,080	1,233	153	10
White	4,852	6,291	1,439	90
Black and other	1,708	1,867	159	10
Married men	1,338	1,808	470	29
Married women	1,143	1,353	210	13
Women who maintain families	563	636	73	5
Other [b]	3,516	4,361	845	53

SOURCE: Congressional Budget Office, based on data from the Bureau of Labor Statistics.

NOTE: Details may not add to totals because of rounding.

a. Industry in which previously employed. Excludes new entrants to the labor force and workers who were self-employed.

b. Primarily other relatives and unrelated individuals.

TABLE 3. SOURCES OF HEALTH INSURANCE COVERAGE OF THE POPULATION, BY AGE, 1990

Source of Insurance	Size of Group (In millions)	As Percent of Population in Age Group
All Ages	245.2	100.0
Employment-Based	151.3	61.7
Own Group	72.9	29.7
Other Group	78.3	31.9
Medicare	30.5	12.4
Medicaid	14.6	6.0
Veterans	0.8	0.3
Other Private	14.7	6.0
None	33.4	13.6
Age 65 and over	29.6	100.0
Employment-Based	1.6	5.5
Own Group	1.2	3.9
Other Group	0.5	1.6
Medicare	27.5	92.9
Medicaid	a	0.0
Veterans	a	0.1
Other Private	0.1	0.4
None	0.3	1.0
Ages 16 to 64	158.0	100.0
Employment-Based	107.3	68.0
Own Group	71.8	45.4
Other Group	35.6	22.5
Medicare	3.0	1.9
Medicaid	7.2	4.6
Veterans	0.8	0.5
Other Private	14.1	8.9
None	25.6	16.2
Under Age 16	57.7	100.0
Employment-Based	42.3	73.3
Own Group	a	0.0
Other Group	42.3	73.3
Medicare	a	0.0
Medicaid	7.4	12.8
Veterans	a	0.0
Other Private	0.5	0.8
None	7.5	13.0

SOURCE: Congressional Budget Office tabulations of data from the March 1990 Current Population Survey

NOTE: Details may not add to totals because of rounding.

a. Fewer than 25,000.

TABLE 4. CHARACTERISTICS OF THE POPULATION WITHOUT HEALTH INSURANCE, BY AGE AND EMPLOYMENT STATUS, 1990 (Levels in Millions)

	Size of Group	Number Without Insurance	As a Percent of Group	As a Percent of all Uninsured
All Ages	245.2	33.4	13.6	100.0
Under 16	57.7	7.5	13.0	22.5
16 to 64	158.0	25.6	16.2	76.6
65 and over	29.6	0.3	1.0	0.9
Employment Status, Ages 16 to 64 Only	158.0	25.6	16.2	100.0
Employed	113.2	16.0	14.2	62.7
Unemployed	6.7	2.4	35.3	9.3
Not in Labor Force	38.1	7.2	18.8	28.0

SOURCE: Congressional Budget Office tabulations of data from the March 1990 Current Population Survey.

NOTE: Details may not add to totals because of rounding.

ESTIMATING THE EFFECT OF THE RECESSION ON THE NUMBER OF PEOPLE WHO WILL LOSE HEALTH INSURANCE

1. **The Number of Additional Unemployed**

   a. In June 1990, 6.6 million people were unemployed.

   b. At the peak of the recession, about 8.6 million people are forecast to be unemployed.

   c. The difference – 2 million people – is the estimated number of additional unemployed resulting from this recession (mostly job losers).

2. **The Proportion of the Additional Unemployed Who Had Their Own Insurance Through Their Employer**

   a. 58 percent of all workers were covered through their own employer before the recession began, as reported on the March 1990 Current Population Survey (CPS).

   b. No direct information is available on whether workers who lose their jobs in this recession are more or less likely to have had insurance through their employer.

3. **The Proportion of Job Losers Who Had Their Own Insurance Who Lose Coverage While Unemployed**

   a. The March 1990 CPS shows that 35 percent of all unemployed job losers still had their own insurance through their previous employer.

   b. Assume that 58 percent of all job losers had previously been covered (based on the coverage of all workers in the survey).

   c. This implies that 40 percent of those who had their own coverage lost it [(58-35)/58 = .40].

   d. Tabulations from the Survey of Income and Program Participation (SIPP) suggest that only 30 percent lost their coverage, with the likelihood of loss rising with the duration of the spell of unemployment.

4. **The Average Number of People Covered by Each Lost Policy**

   a. The March 1990 CPS shows 72.9 million people covered by their own group policy and 78.3 million people covered by someone else's group policy (generally spouses and children of covered workers).

   b. Assume that the average unemployed worker who loses coverage as a result of the recession had 2.07 people on the lost policy – the worker plus the average number of dependents (78.3/72.9 = 1.07).

5. **Estimated Effect**

   a. 2 million times .58 times .40 times 2.07 equals 1 million.

   b. This estimate is subject to considerable uncertainty because the magnitude of each of the four determinants on which it is based is uncertain.

Mr. **Gradison**. Thank you, Mr. Chairman. I appreciate this opportunity to express these views at the outset.

Chairman **Stark**. I wanted to agree with the gentleman from Ohio because this would hardly touch the surface of the uninsured. It is my intention, as soon as we can finish drafting, to introduce legislation that would give a tax credit for celibacy, tax obesity and tax divorce, thereby encouraging stronger families and more exercise, abstinence, and the rest of the Dr. Sullivan plan, which is, from my understanding, the administration's approach to solving insurance and health care for the uninsured.

Mr. Pease, did you have a statement?

Mr. **Pease**. Thank you very much, Mr. Chairman. Sign me up as a cosponsor of this innovative new bill that you are thinking about to end obesity once and for all.

Mr. Chairman, I very much appreciate the indulgence of the Chair in allowing me to make an opening statement. I would ask that a prepared statement that I have be included in the record, which I am sure is included by unanimous consent.

Chairman **Stark**. Without objection.

[The prepared statement follows:]

STATEMENT OF CONGRESSMAN DON J. PEASE
HOUSE WAYS AND MEANS COMMITTEE, SUBCOMMITTEE ON HEALTH
THURSDAY, MARCH 21, 1991
9:30 A.M., 1100 LONGWORTH HOUSE OFFICE BUILDING

I would like to thank you, Chairman Stark and members of the Health Subcommittee, for allowing me to come here today to participate in your hearing on the issue of health insurance for the long-term unemployed. You may know that this has been a concern of mine for many years. It is indeed unfortunate that the phrase "long-term unemployed" is a unfamiliar one to the residents of my district in Ohio. The current recession has only served to exacerbate what has become a chronic economic downturn in northeastern Ohio.

Mr. Stark, I commend you for your own innovative approach to the problem of health care for the long-term unemployed. As I understand it, your bill would allow individuals who qualify for extended unemployment compensation also to be entitled to enroll in the Medicare program. The individual would be required to pay a small weekly premium that would be deducted from his or her weekly unemployment compensation check. This, in combination with Mr. Downey's bill to expand the pool of workers eligible for extended unemployment compensation benefits, would give many people access to health benefits that they would otherwise not have had access to.

Along these lines, Mr. Stark, I would like to call your attention to my own bill, the Universal Health Insurance Act of 1991, which would, like yours, serve to allow the unemployed and low-income workers greater access to health benefits. It would create affordable, comprehensive health coverage that citizens could buy into if they so desired. Building on the nation's existing system of private and non-profit health insurance, my plan would be non-coercive and would require reasonable payment from individuals receiving the insurance coverage.

Under my plan, state insurance pools would be created, based on competitive bidding among insurance carriers. Citizens could then purchase the insurance for a sliding scale of 6-8% of their income and assets. This income and asset level would be determined by an independent agency, similar to the way need levels are determined for student loans. The portion of the cost of the insurance not covered by the sliding scale payment would be picked up by the federal government.

What would be the cost to the federal government? It would not be cheap--but no program could be that aims to fill such a major void in our country's health care system. Some of the cost of the plan would be offset by increasing the tax on cigarettes (an idea supported by over 80% of the American people).

My plan would be completely voluntary, and, although it would not be tied to employment, employers could offer insurance under my plan as an option to their employees who choose to participate. Employers would be encouraged to offer health insurance through the imposition of a new health plan employment tax, which would be waived for employers already offering adequate insurance plans to their employees.

I urge you to look at my plan as you consider others pending before your subcommittee. As you know, the problem of the uninsured is not diminishing. It is getting worse, and we need to take immediate steps to remedy it.

Thank you.

Mr. PEASE. I would just say that I really am very, very pleased that the chairman has called this hearing because it brings together a couple of long-standing concerns of mine. One is the concern for unemployed Americans. I have been working for eight years now trying to reform the unemployment compensation system. The bill that Mr. Downey, Mr. Levin and I introduced the other day would certainly go a long way toward recognizing the problem of extended unemployment, those who cannot go back and do not go back within the first 26 weeks.

I have also been interested for at least that long in trying to provide health insurance for those who cannot otherwise afford it. And I have a bill of my own, as the chairman knows, which follows an approach of making health insurance available through the commercial system for 37 million people. That bill is considerably more ambitious and expensive than some of the others.

What Chairman Stark has done with this proposal of his is to be innovative and try to bring together existing Federal programs and try to make use of Medicare, a proven, time-tested program for delivering medical insurance, make that available to unemployed Americans. Of course, it is not a final solution or a complete solution, but I think it is a step in the right direction. It is the sort of thing that we need to be thinking about if we are going to really tackle the growing and very serious problem of people who are unemployed and cannot provide for the health care of their families.

I thank the chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to thank you for having this hearing and focusing attention on one of the greatest failures of our health care system: the fact that when you lose a job, usually you are also losing your health care benefits.

Most Americans' health coverage comes from their employment, which means that losing a job in America hurts a worker more than it does in any other industrial democracy. The loss of health insurance over an extended period can hit families as hard as the loss of the job income.

This is especially true right now in the Pacific Northwest where the need to protect our remaining old-growth forests has combined with the nationwide recession to put thousands of people out of work in our logging and mill towns. These skilled jobs have been at risk in the past recessions, but this time there is a real chance that they will not reappear because of the dwindling supply of available timber. And alternative jobs are especially hard to find in isolated communities like Forks, Washington, and Coos Bay, Oregon. Many of those workers will need affordable health care coverage, as well as extended unemployment benefits. Furthermore, the small health care practices and facilities serving these towns will need paying patients, not a greater burden of uncompensated care.

So I want to commend your actions, Mr. Chairman, to help meet those needs, and I hope that we will be able to move legislation this year to reform our unemployment insurance system. Basic affordable health coverage should be an element of that reform, and I want to work with you and Mr. Downey and the other members of this subcommittee and the full committee to make that possible.

Thank you very much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Very briefly, Mr. Chairman, I just want to throw out the suggestion there will be considerable concern raised, as Mr. Gradison has already, about whether this is the appropriate approach. I do hope that the witnesses, especially those who oppose this approach, might suggest something else.

One of the drawbacks with this approach is it would tie into a program, the extended benefit program, as I understand it, that doesn't cover very many people. Michigan just triggered into extended benefits; it took close to 10 percent unemployment to do so.

There are other concerns that people have with this approach, but, again, I do hope that those witnesses who don't believe this is the appropriate way to proceed will suggest to us other ways how those who have been working, and working hard, and then thrown out of work, who can't buy into an employer coverage, how they might be protected from not only losing their jobs but losing health insurance.

Thank you, Mr. Chairman.

Chairman STARK. Are there other members who wish to be recognized?

[No response.]

Chairman STARK. If not, at this point our first panel will be called, and it includes two witnesses who are experts in the fields of labor and health economics. I hope they will provide the committee with some insight into how recessions and unemployment affect the availability of health insurance. We are pleased to welcome Walter Corson, the vice president of Mathematica Policy Research in Princeton, and Dr. Katherine Swartz, a senior research associate of the Urban Institute.

We are going to run a time clock on you, but I assure you that is only to let you expand on your written testimony, which will appear in the record in its entirety. The committee will then have a chance to review that and subsequently inquire and let you expand your testimony in that format.

Mr. Corson.

STATEMENT OF WALTER CORSON, VICE PRESIDENT, MATHEMATICA POLICY RESEARCH, PRINCETON, NJ

Mr. CORSON. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to have this opportunity to appear here today. I have been asked by the subcommittee to provide background information on long-term unemployment insurance recipients for your use in assessing their likely health insurance coverage.

I will base my discussion on a recent nationally representative study of UI recipients and exhaustees that I and my colleagues at Mathematica Policy Research conducted. For purposes of this testimony, I will focus on UI exhaustees since these individuals would receive extended UI benefits and, potentially, health insurance under proposed legislation.

Individuals who lose their jobs can be covered by health insurance because their health insurance coverage continues for some period after layoff, because they are covered through another family member, because they are covered through a public program like Medicare or Medicaid, or because they purchase insurance. Our survey of UI exhaustees provides no direct information about these possibilities, but it does provide descriptive information that provides some clues about the likelihood of health insurance coverage. This evidence suggests to me that substantial numbers of exhaustees are not likely to have health insurance coverage.

Information on group health plans published in 1980 by the National Commission on Unemployment Compensation indicates that, at that time, very few workers were covered by health insurance plans that would extend for four or more months following the loss of a job. This suggests that few exhaustees are likely to have extended health insurance coverage since most exhaustees will have collected UI benefits for at least four months.

The National Commission study also found that the industries with the longest post-layoff health insurance coverage were manufacturing and construction, industries that accounted for about 45 percent of the UI exhaustees in 1988, the year of our study. Since 1988 was a non-recessionary period, these industry characteristics may differ currently. In fact, comparisons of the characteristics of exhaustees in our sample with exhaustees during earlier recessionary periods suggest that the proportion of exhaustees coming from manufacturing is likely to increase during a recessionary period. Nevertheless, substantial numbers of exhaustees will still come from other industries that are less likely to have extended health insurance coverage.

Other factors, such as union membership or long job tenure, may also be associated with a greater likelihood of having extended health insurance coverage. Twenty-four percent of the exhaustees were union members, and over half of the exhaustees had worked for their pre-UI employer for two or more years. Again, however, substantial numbers of exhaustees do not fall in these categories.

As noted previously, UI exhaustees may obtain health insurance coverage through other family members. Just over 40 percent of the exhaustees had working spouses who may have had health insurance coverage through their jobs.

Another way in which exhaustees might obtain health insurance coverage is through Medicare or Medicaid. However, Medicare is an option for few exhaustees; less than two percent are age 65 or over. Medicaid is probably also an option for relatively few exhaustees since only seven percent received any welfare benefits.

The final way in which UI exhaustees could obtain health insurance coverage is by purchasing insurance, but many exhaustees may not have the financial resources to do so. Many exhaustees had low paying jobs and low family incomes prior to receiving UI. In addition, a recent CBO study found that 20 percent of long-term UI recipients had family incomes below the poverty line, and another 27 percent would have had family incomes below the poverty line if they were not receiving UI benefits.

In summary, the evidence reported here suggests that substantial numbers of UI exhaustees are not likely to have health insurance coverage. Most health plans do not extend coverage long enough to cover the long-term unemployed, less than half of the exhaustees have working spouses who might have had health insurance, and few exhaustees are likely to be eligible for Medicare or Medicaid. In addition, many exhaustees do not have the financial resources to purchase insurance.

Thank you.

[The prepared statement follows:]

STATEMENT ON HEALTH INSURANCE AND THE UNEMPLOYED
FOR THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
MARCH 21, 1991

Walter Corson
Vice President
Mathematica Policy Research

Mr. Chairman and members of the subcommittee, I am pleased to have this opportunity to appear here today. I have been asked by the subcommittee to provide background information on long-term unemployment insurance recipients for your use in assessing their likely health insurance coverage.

I will base my discussion on a recent nationally representative study of UI recipients and exhaustees that I and my colleagues at Mathematica Policy Research conducted. For purposes of this testimony, I will focus on UI exhaustees since these individuals would receive extended UI benefits and, potentially, health insurance under proposed legislation.

Individuals who lose their jobs can be covered by health insurance because their health insurance coverage continues for some period after layoff, because they are covered through another family member, because they are covered through a public program like Medicare or Medicaid, or because they purchase insurance. Our survey of UI exhaustees provides no direct information about these possibilities, but it does provide descriptive information that provides some clues about the likelihood of health insurance coverage. This evidence suggests that substantial numbers of exhaustees are not likely to have health insurance coverage.

Information on group health plans collected for and published in 1980 by the National Commission on Unemployment Compensation (Malhotra and Wills, 1980) indicates that, at that time, very few (6 percent) workers were covered by health insurance plans that would extend for 4 or more months following the loss of a job. This suggests that few exhaustees are likely to have extended health insurance coverage since most exhaustees will have collected UI benefits for over 4 months.[1]

The National Commission study also found that the industries with the longest post-layoff health insurance coverage were manufacturing and construction, industries that accounted for about 45 percent of the UI exhaustees in 1988, the year of our study (see Table 1). Since 1988 was a non-recessionary period, these characteristics may differ in the current recessionary period. In fact, comparisons of the characteristics of the exhaustees in the sample with exhaustees during earlier recessionary periods suggest that the proportion of exhaustees coming from manufacturing is likely to increase during a recessionary period. Nevertheless substantial numbers of exhaustees will still come from other industries that are less likely to have extended health insurance coverage.

Other factors, such as union membership or long job tenure, may also be associated with a greater likelihood of having extended health insurance coverage. As also shown in Table 1, 24 percent of exhaustees were union members and over half of the exhaustees had worked for their pre-UI employer for 2 or more years. Again, however, substantial numbers of exhaustees do not fall in these categories.

As noted previously, UI exhaustees may obtain health insurance coverage through other family members. Just over 40 percent of the exhaustees had working spouses who may have had health insurance coverage through their jobs.

Another way in which exhaustees might obtain health insurance coverage is through Medicare or Medicaid. However, Medicare is an option for few exhaustees: less than 2 percent are age 65 or over and 8 percent received social security or railroad retirement benefits. Medicaid is probably also an option for relatively few exhaustees since only 7 percent received AFDC, SSI or other welfare benefits.

The final way in which exhaustees could obtain health insurance coverage is by purchasing insurance, but many exhaustees may not have the financial resources to purchase insurance. Many exhaustees had low paying jobs and low family incomes prior to receiving UI. In addition, a recent Congressional Budget Office (CBO) study found that 20 percent of long-term UI recipients had family incomes below the poverty line and another 27 percent would have had family incomes below the poverty line if they were not receiving UI benefits.

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[1] The majority of UI exhaustees collect UI benefits for 6 months.

In summary, the evidence reported here suggests that substantial numbers of UI exhaustees are not likely to have health insurance coverage. Most health plans do not extend coverage long enough to cover the long-term unemployed, less than half of the exhaustees have working spouses who might have health insurance, and few exhaustees are likely to be eligible for Medicare or Medicaid. Finally many exhaustees do not have the financial resources to purchase insurance.

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TABLE 1

PRE-UI JOB CHARACTERISTICS
(Percent)

	Exhaustees	Nonexhaustees
Weekly Wage		
$200 or Less	21.0	16.7
$201 to $300	23.9	26.4
$301 to $400	18.8	20.3
$401 to $500	12.5	9.8
$501 to $800	16.8	21.4
$801 or More	6.9	5.5
Hours per Week	7.6	6.7
34 and Under	6.5	4.7
35 to 39	46.2	51.7
40	10.2	11.5
41 to 45	29.5	25.4
46 or More		
Job Tenure		
Less Than 6 Months	15.0	12.1
6 to 12 Months	15.3	15.3
13 to 24 Months	16.0	14.3
25 to 36 Months	10.8	9.9
More Than 36 Months	42.8	48.5
Had Previous Layoff from Pre-UI Job	25.5	36.2
Had Layoff on a Regular Basis	13.4	21.1
Union Member	24.2	30.5
Industry		
Agriculture/Forestry/Fishing	4.0	3.2
Mining	1.9	1.7
Construction	14.3	16.8
Durable Manufacturing	16.9	24.7
Nondurable Manufacturing	14.0	18.0
Transportation/Public Utilities	5.0	4.3
Wholesale Trade	3.9	3.2
Retail Trade	11.6	8.6
Finance/Insurance/Real Estate	5.6	3.3
Services	19.0	13.8
Public Administration	3.8	2.6
Seasonal Industry	25.2	24.6
Occupation		
Managerial/Professional	11.6	8.3
Technical and Related Support	1.8	2.0
Sales	6.8	6.0
Administrative Support	19.4	12.2
Service Occupations	9.6	6.4
Mechanics and Repairers	3.9	5.5
Construction and Extractive	8.9	11.4
Precision Production	2.3	2.8
Machine Operators	16.2	25.9
Transportation and Material Moving	6.2	7.3
Handlers	8.6	8.2
Farming, Forestry, and Fishing	4.7	4.2
Sample Size	1,920	1,009

SOURCE: Mathematica Policy Research (1990).

TABLE 2

THE DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF EXHAUSTEES AND NONEXHAUSTEES

	Exhaustees	Nonexhaustees
Gender (Percent)		
Male	55.1	60.4
Female	44.9	39.6
Age (Percent)		
Younger Than 25	9.1	13.4
25 to 34	31.4	34.2
35 to 44	25.3	25.0
45 to 54	19.3	16.7
55 to 64	13.5	9.2
65 and Older	1.5	1.6
Race/Ethnicity (Percent)		
White	69.2	76.9
Black	14.8	10.9
Hispanic	11.2	8.9
Other	4.7	3.3
Highest Diploma or Degree Received (Percent)		
Less Than High School	22.6	20.9
High School/GED	51.2	55.9
Vocational/Technical/Associate's	13.4	13.5
Bachelor's	10.1	7.9
Post-Bachelor's	2.6	1.8
Other	0.1	0.0
Married/Living Together at Layoff	58.7	62.4
Married/Living Together at Interview	59.8	65.8
Have Dependents	48.2	51.6
Have Dependent Children Under Age 18	42.2	47.4
Spouse Worked at Layoff	39.8	41.8
Spouse Worked at Interview	42.1	46.9
Household Income 1987		
Under $10,000	21.2	14.5
$10,000 to $20,000	32.0	32.9
$20,001 to $30,000	21.6	24.5
$30,001 to $40,000	10.9	15.4
$40,001 to $50,000	7.5	7.5
$50,001 or More	6.9	5.3
Sample Size	1,920	1,009

SOURCE: Mathematica Policy Research (1990).

[a] These percentages are computed over the entire sample. The percent of married couples with a working spouse can be computed by dividing the percent of the sample with a working spouse by the percent of the sample who were married. For example, at layoff, 67.8 percent of the married exhaustees had a working spouse.

Chairman STARK. Thank you.

Ms. Swartz.

STATEMENT OF KATHERINE SWARTZ, PH.D., SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. SWARTZ. Thank you for inviting me to discuss the impact of the current recession on the loss of employer-group health insurance. I would like to make three points, which I will summarize first and then discuss more fully.

First, as we have heard, the recession is clearly increasing the average length of time that people are unemployed. This means that the length of time unemployed people spend in a spell without health insurance is now longer than it was only a few years ago. As people remain unemployed longer, they also use up resources they may have had to purchase health insurance either through their previous employer group under COBRA or on their own.

The second point is that this recession appears to be causing many primary earners in families to lose their jobs. Families most often obtain health insurance coverage through the employer of the primary earner, so the current recession is causing more people to lose health insurance coverage than just those who lose their jobs.

The third point is that the recession has coincided with a time when health insurance premiums have increased significantly, particularly for medium and small employers. The combination of higher premiums and a weak economy has caused many employers, especially small employers, to no longer offer health insurance. Thus, the recession is not only increasing the number of people without health insurance because of job losses. It is also increasing the number of people without health insurance because more employers are no longer offering health insurance as a benefit. I would like to briefly expand on each of these points.

For the past year, my colleague, Tim McBride, and I have been analyzing the lengths of time that people spend without health insurance coverage. Our research is based on the 1984 Panel of the Survey of Income and Program Participation, known as the SIPP, which covers the time period of late 1983 through mid-1986. In the mid-1980s, half of the adults who experienced time without health insurance were uninsured for 4 months or less. Three-quarters of the adults were uninsured for less than a year. Only 15 percent of the adults had spells without health insurance that lasted more than 2 years.

Among the people with shorter uninsured spells, we have found that people who do not lose employment are most likely to have the shortest spells. Such people appear to be moving from one job to another and are uninsured simply because they go through a probationary employee period of 90 to 120 days before obtaining health insurance with the new employer. But not surprisingly, people who were unemployed had somewhat longer spells without insurance on average. Among unemployed adults without health insurance, more than a third—36 percent—had spells that lasted 4 months or less, and another 22 percent had spells that last between 5 and 8 months.

In the mid-1980s, the unemployment rate was about 7 percent, which is not very different from what it is now. However, that similarity is deceptive because the unemployment rate had been steadily declining from highs above nine percent during the recession of 1982–83. The current recession, as you know, appears to be driven by uncertainty about the values of assets and consequent credit availability. This in turn is causing many firms, particularly those that are tied to assets in real estate, to have difficulty obtaining credit, and they are laying people off in order to cut losses. In today's slack labor market, I expect that the average duration of a period of unemployment is longer than it was in the mid-1980s. Similarly, I expect that the distribution of uninsured spell lengths among the unemployed has shifted towards longer spells, so that I expect now less than a third of the unemployed would be in uninsured spells lasting less than four months, and that a larger proportion would have spells that last between 5 and 8 months.

The second point that I want to leave you with is that the recession appears to be causing many primary earners in families to lose their jobs and the family's access to health insurance. Despite stories in the media that have focused on the plight of managers, the current recession appears to be a classic recession in terms of predominantly affecting hourly wage, blue-collar workers. Manufacturing, construction, and retail trade are the industry sectors that have been hardest hit, with the brunt of the loss in jobs occurring in the Northeast part of the country. This pattern of job losses has implications for who loses health insurance as a result of the recession. Workers in the Northeast have historically had health insurance as a fringe benefit of employment more often than workers in the other three geographic regions of the United States. Thus, increasing unemployment in the Northeast is more likely to lead to rising numbers of people without health insurance than would similar unemployment increases in other parts of the country.

Manufacturing has traditionally been the employment sector with the highest proportions of workers with health insurance coverage, about 90 percent. Our research on the lengths of time people spend in uninsured spells indicates that people employed in manufacturing or the public sector have the highest probabilities that an uninsured spell will end quickly. But in a period of rising unemployment in manufacturing, the probability that an uninsured spell will end within four months must be lower than it was in the time period that the SIPP was collected.

A high proportion of the workers employed in manufacturing and construction are primary earners in their families, and as such they are also the primary conduit for health insurance coverage for their families. This creates a multiplier effect in terms of the number of people who become uninsured as a result of one person losing his or her job. In the 1982–83 recession, we observed a large increase without health insurance as a result of the loss of jobs, particularly in manufacturing. The current recession's pattern of job losses in manufacturing and construction, especially in the Northeast, strongly suggests that we will see a repeat of the 1982–83 recession increase in the number of uninsured that exceeds the number of people who become unemployed. In assessing the connection between rising unemployment and the number of people without health insurance, we need to remember that other family members are affected as well.

In the interest of being brief, let me just say my summary paragraph.

In sum, there is no doubt that the recession is causing more people to lose their health insurance coverage and that the average length of time unemployed people are without health insurance is increasing. From a policy point of view, the fact that more people will now be without health insurance for longer periods of time adds some urgency to targeting assistance to those with long uninsured spells.

Thank you very much.

[The prepared statement follows:]

THE IMPACT OF THE CURRENT RECESSION ON THE LOSS OF EMPLOYER-GROUP HEALTH INSURANCE

by Katherine Swartz, Ph.D.[1]

Thank you for inviting me to discuss the impact of the current recession on the loss of employer-group health insurance. I would like to make three points, which I will summarize first and then discuss more fully.

First, the recession is clearly increasing the average length of time that people are unemployed. This means that the length of time unemployed people spend in a spell without health insurance is now longer than it was only a few years ago. As people remain unemployed longer, they also use up resources they may have had to purchase health insurance either through their old employer-group under COBRA or on their own.

Second, this recession appears to be causing many primary earners in families to lose their jobs. Families most often obtain health insurance coverage through the employer of the primary earner so the current recession is causing more people to lose health insurance coverage than just those who lose their jobs.

Third, the recession has coincided with a time when health insurance premiums have increased significantly, particularly for medium and small employers. The combination of higher premiums and a weak economy has caused many employers (especially small employers) to no longer offer health insurance. Thus, the recession is not only increasing the number of people without health insurance because of job losses. It is also increasing the number of people without health insurance because more employers are no longer offering health insurance as a benefit. I will briefly expand on each of these points.

For the past year, my colleague, Tim McBride, and I have been analyzing the lengths of time that people spend without health insurance coverage. Our research is based on the 1984 Panel of the Survey of Income and Program Participation (SIPP), which covers the time period of late 1983 through mid 1986. In the mid 1980s, half of the adults who experienced time without health insurance were uninsured for four months or less. Three-quarters of the adults were uninsured for less than a year. Only 15 percent of the adults had spells without insurance that lasted more than two years.

Among the people with shorter uninsured spells, we have found that people who do not lose employment are most likely to have the shortest spells. Such people appear to be moving from one job to another and are uninsured simply because they go through a probationary employee period of 90 to 120 days before obtaining health insurance with the new employer. Not surprisingly, people who were unemployed had somewhat longer spells without insurance on average. Among unemployed adults without health insurance, 36 percent had spells that lasted 4 months or less, and another 22 percent had spells that last between 5 and 8 months.

In the mid 1980s (the time in which our data was collected), the unemployment rate was about 7 percent, which is not very different from what it is now. However, that similarity is deceptive because the unemployment rate had been steadily declining from highs above 9 percent during the recession of 1982-83. The current recession, as you know, appears to be driven by uncertainty about the values of assets and consequent credit availability. This in turn is causing many firms (particularly those that are tied to assets in real estate) to have difficulty obtaining credit, and they are laying people off in order to cut costs. In today's slack labor market, I expect that the average duration of a period of unemployment is longer than it was in the mid 1980s. Similarly, I expect that the distribution of uninsured spell lengths among the unemployed has shifted towards longer spells so that now less than a third of the unemployed would be in uninsured spells lasting four months or less, and a larger proportion have spells that last between 5 and 8 months.

The second point that I want to leave you with is that the recession appears to be causing many primary earners in families to lose their jobs and the family's access to health insurance. Despite stories in the media that have focused on the plight of managers, the current recession appears to be a classic recession in terms of predominantly affecting hourly wage, blue collar workers. Manufacturing, construction, and retail trade are the industry sectors that have been hardest hit, with the brunt of the loss in jobs occuring in the Northeast part of the country. This pattern of job losses has implications for who loses health insurance as a result of the recession. Workers in the Northeast have historically had health insurance as a fringe benefit of employment more often than workers in the other three geographic regions of the U.S. Thus, increasing unemployment in the Northeast is more likely to lead to rising numbers of people without health insurance than would similar unemployment increases in other parts of the country.

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[1] Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 21, 1991. The author is a Senior Research Associate at The Urban Institute, 2100 M Street, NW, Washington, D.C. 20037, 202-857-8646. Opinions expressed are those of the author and should not be construed as representing opinions or policy of The Urban Institute or sponsors of The Urban Institute.

Manufacturing has traditionally been the employment sector with the highest proportions of workers with health insurance coverage, about 90 percent. Our research on the lengths of time people spend in uninsured spells indicates that people employed in manufacturing or the public sector have the highest probabilities that an uninsured spell will end quickly. But in a period of rising unemployment in manufacturing, the probability that an uninsured spell will end within four months must be lower than it was in the time period of the SIPP.

A high proportion of the workers employed in manufacturing and construction are primary earners in their families, and as such they are also the primary conduit for health insurance coverage for their families. This creates a multiplier effect in terms of the number of people who become uninsured as a result of one person losing his or her job. In the 1982-83 recession, we observed a large increase in the total number of people without health insurance as a result of the loss of jobs, particularly in manufacturing. The current recession's pattern of job losses in manufacturing and construction, especially in the Northeast, strongly suggests that we will see a repeat of the '82-83 recession increase in the number of uninsured that exceeds the number of people who become unemployed. In assessing the connection between rising unemployment and the number of people without health insurance, we need to remember that other family members are affected as well.

The third point that I want to make this morning is that the current recession has coincided with rapidly rising premiums for health insurance. The large increases in premiums have been felt particularly by smaller employers. The impact of the recession on their businesses appears to be causing some smaller firms to drop health insurance benefits. Thus, even if their workers are not losing their jobs, they are losing access to employer-group health insurance as a result of the recession.

In sum, there is no doubt that the recession is causing more people to lose their health insurance coverage and that the average length of time unemployed people are without health insurance is increasing. From a policy point of view, the fact that more people will now be without health insurance for longer periods of time adds some urgency to targeting assistance to those with long uninsured spells.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Chairman, I understand from our previous discussions of this issue, within the subcommittee as well as the excellent testimony that we have just received, how difficult it is to make estimates that are current on something like this because of the uncertainties which exist. I would, however, welcome any comments the panelists would care to make about the estimate we received from Dr. Reischauer.

I appreciate that it is just a judgment call, but basically what he said to us is that his estimate was that about 2 million people—I am reading now—"is the estimated number of additional unemployed resulting from the recession, mostly job losers," and that once he factors in those who are able to continue to get coverage through some of the means which you have mentioned yourselves, he comes down to a figure of about a million, about half of that 2 million that would be added to the rolls of the uninsured.

He also says—and I think it useful to read this too, "This estimate is subject to considerable uncertainty because the magnitude of each of the four determinants on which it is based is uncertain."

Does that 50-50, that million out of two million, sound in the ball park?

Ms. SWARTZ. I would not disagree with that in the sense that it is an estimate and it is probably from the Current Population Survey. I would just add that in the mid-1980's, from the 1987 Current Population Survey, there were three million unemployed uninsured. So that adding another million unemployed uninsured is adding a large number to what is probably a current estimate now of about three million unemployed uninsured before you add this one million from the recession.

Mr. GRADISON. Well, I should have pointed out that that million includes dependents, so that the number of those who have lost their jobs out of the 2 million who don't have health insurance coverage in this estimate is substantially lower than a million. It is four or five hundred thousand, and then the rest is the dependents. But this is based upon, you are quite right, the March 1990 Current Population Survey.

Ms. SWARTZ. And my number of 3 million was just adults. It was not including dependents.

Mr. GRADISON. Right. I thought that was the case. Thanks.

Mr. CORSON. I would like to add that the 50-50 split may be a little different when we talk about unemployment insurance exhaustees since they have been unemployed for at least four months and most for six months. It may be a little higher rate that is uncovered for that population.

Mr. GRADISON. Thank you, Mr. Chairman. I appreciate it. This is helpful.

Chairman STARK. Would the gentleman yield?

Mr. GRADISON. Of course, and I have completed my questioning. Thank you, Mr. Chairman.

Chairman STARK. As I recall, Dr. Reischauer indicated that there might be a half million to a million people unemployed if the recession ended in June. However, if we are wrong or our best hopes aren't realized, and if the recession went on to September, that these numbers would go up almost exponentially. So while I don't mean to a harbinger of bad news as a way to press legislation, we are dealing with a very fragile point. We could get several more million, I think, if this thing extended.

Mr. Gradison. That is true, and my recollection is that at the time we held the joint hearing with the other subcommittee last year on this subject, CBO was somewhat reluctant about giving us cost estimates for that very reason. And we don't have, of course, a cost estimate, to my knowledge, on 1492 because it was just introduced. But it has got to be in the—above a billion dollars. I mean, I don't know how else to say it but that. That is just a wild guess.

Chairman Stark. H.R. 1492, this bill?

Mr. Gradison. Yes. So, you know, we are not talking about a trivial sum. And we may be uncertain by a factor of two or three in terms of what this might cost—which would be understandable because we don't have a crystal ball about the economy.

Chairman Stark. What is a thousand million?

Mr. Gradison. That is where the billion came from. That is where I came up with that brilliant number of mine.

What I am trying to say is it is a large sum.

Chairman Stark. One to two billion would be the cost.

Mr. Gradison. Yes, that is what I would expect. In this environment, maybe because I have been so active for too long on the Budget Committee, that is a big number.

Chairman Stark. We will continue to inquire if the witnesses can bear with us for about five minutes for a vote. The first one back in order of seniority can proceed to interrogate.

Bill, you chair it.

Mr. Levin [presiding]. Mr. Coyne.

Mr. Coyne. Ms. Swartz, in your testimony, you state that the length of time that unemployed people spend in one particular spell without health insurance is now longer than it was just a few years ago. Are these individuals included in the traditional number of 35 to 40 million uninsured people?

Ms. Swartz. Yes and no. The traditional numbers that you hear of between 31 and 37 million are basically from point-in-time estimates; that is to say, they are gathered at one point during the year. The Current Population Survey is gathered in March of every year.

When you gather data at a point in time, you are more likely to find people in longer spells without health insurance—or whatever we are talking about, whether it is poverty or unemployment—than you are people with short spells. So that in our estimates of the numbers of people who have spells that last between one and four months, five to eight months, nine to 12 and beyond, we are finding a larger proportion of unemployed and, for that matter, all adults who have shorter spells. So that they are more likely to be missed by these point-in-time collections of data.

On the other hand, if, as I suspect, the distribution of lengths of time that people are without health insurance is moving to the right—that is, that more people are having slightly longer spells—we would be more likely to be picking them up now at point-in-time data collection efforts as with the Current Population Survey.

However, the most recent CPS is from March 1990, before really this recession kicked in, and so we don't yet have, I think, an estimate of the impact of the recession on the number at a point in time without health insurance.

So what I was speaking to was what happens to the length of time that somebody is without health insurance, the consequence in this case of being without a job where they have lost employer-group health insurance.

Mr. COYNE. So as a general statement, they are not included in that larger figure.

Ms. SWARTZ. You wouldn't find them as often in the CPS. That is right. When you talk about looking at a point in time, 11 percent of the adults without health insurance are unemployed as compared with 60 percent are employed. Those people are more likely to be in longer spells. So the people who have short spells without health insurance because they have short spells of being unemployed are not generally picked up. So it is length-biased in terms of the point-in-time estimate. You are getting too many of the longer spells and not enough of the shorter spells.

Mr. COYNE. Well, if they were to be included in the 37 or 38 million, what would you estimate that that would increase that figure by? Do you have any idea?

Ms. SWARTZ. No, I don't have a good idea. You know, the general numbers that the Bureau of the Census has provided from the SIPP as well are that we have 62, 63 million people who have at least 1 month without health insurance over the course of 28 months, but that includes children. So my own guess is that somehow the 3 million from the 1987 CPS, which is probably about 3.5 million now, if you were to add in people who over the course of a year have a short uninsured spell, that number could be as much as two times higher. But I don't know what the number is. No one does.

Mr. COYNE. Thank you.

Mr. LEVIN. Let me just ask a quick question, and then I will have to join my colleagues in voting. Maybe somebody will be coming back almost instantaneously.

I take it from your testimony and others that we really don't have very close data as to how many people would be covered, because this is tied into EB and we are not sure how many people will be covered by extended benefits, and we don't really know how many of those would be able to buy into coverage that they had, right?

Mr. CORSON. That is correct.

Mr. LEVIN. We are spending a lot of time, though, talking about numbers, kind of statistics. I think we ought to look also at the impact on the individuals who have been working or thrown out of work and then have no coverage at all. Are there some good studies as to what happens to the family when, after years of coverage, they are thrown out and all of a sudden have no insurance? I mean, do you know? Is there some good literature on the subject of the impact on families, family structures, who have had the protection of insurance coverage and then, boom, lose it?

Ms. SWARTZ. I don't personally know of such studies, although I suspect that some of the witnesses you are having later this morning may be able to speak to that.

I do know of stories that friends of mine who are physicians tell about their patients who put off coming into the office and put off other procedures that they have advised them to have. And it is solely because they have lost their health insurance coverage, and they are trying to keep pretty careful track of the money, their assets that they have remaining. So they just delay.

Mr. LEVIN. And also the impact on health facilities. There is not only a social cost; there is an economic cost. Are there good studies on the economic cost of having people shift from health care to using emergency rooms?

Mr. CORSON. Not that I am aware of.

Mr. LEVIN. Okay. If you will just hold forth, just drink a cup of coffee or water out of those wonderful Ways and Means pitchers, somebody will be back shortly.

[Recess.]

Chairman STARK [presiding]. Mr. Cardin will inquire.

Mr. CARDIN. Thank you, Mr. Chairman.

There is no question that the recession will add to the number of people who are uninsured. Whether it is a million additional individuals as a result of someone becoming unemployed that will now be uninsured, or whether it is less or more, there is no question about it.

But I am curious as to whether anyone here believes, when we pull out of this recession, that the number of people who were uninsured as a result of the recession will all of a sudden in number become insured. In other words, will the creation of new jobs in our economy create the equivalent number of people who are insured that the recession and loss of jobs created in uninsured? I am just curious as to whether either one of you believe there is any correlation between employment growth and the number of insured persons?

Ms. SWARTZ. In the 1982–83 recession, we lost a large number of jobs in manufacturing which did not get replaced. That is to say, when we came out of that recession, not all of the job losses were then filled again. And I think none of us really know what is going to happen at the end of this recession in terms of will all of these manufacturing jobs come back, and therefore would you anticipate that a large number of these unemployed uninsured will become employed and insured. But if the economy continues to grow in terms of job increases in the service sector, I think then the answer is that not all of these people who lose their health insurance as a result of losing their jobs when they become reemployed will get health insurance as well, because the service sector is not a sector that has a high proportion of employees with health insurance as a benefit.

The second part of my answer is that given the rapid increase in premiums for health insurance that employers are facing, I suspect that an increasing number of employers are going to resist either offering health insurance as a benefit, particularly if they are small employers, unless they have subsidized, from either the State or the Federal Government, pools to which their firm can then become a member offering health insurance to their employees.

Mr. CARDIN. Ms. Swartz, let me comment on that point. I think the point that you raised earlier is very true, and that is whether it is the justification of the recession, economic times, or whatever, many employers now are not providing insurance. And the likelihood that they all of a sudden will start to provide insurance coverage without some change in Federal policy seems to me to be remote. Although we are here today, I know, Mr. Chairman, on the impact of the unemployment and recession on the uninsured, it seems to me that we are dealing with a rather small part of the problem of those people who are uninsured today. And even if we could resolve the problem of those people who are unemployed and are not qualified for Medicare or Medicaid or don't have the resources to pay for their own private insurance, we are going to have a continuing growth in people who are uninsured who have jobs.

Ms. SWARTZ. I would agree with that.

Mr. CARDIN. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Russo.

Mr. RUSSO. Thank you very much, Mr. Chairman.

Just to follow up on what Mr. Cardin said, it seems to me that although the goals of this legislation are laudable and something that we ought to strive towards, it seems that it is another one of those piecemeal approaches to solving a problem that needs a comprehensive reform.

Chairman STARK. Oh, is there a bill like that?

Mr. RUSSO. Well, there is one, Pete. H.R. 1300. You can get on it any time you want. My concern is that we continually try to address different pockets of problems and never deal with the major problem, which is universal access for everybody.

Would you like to make any comment on that?

Ms. SWARTZ. To those of you who have read what I have written, this will not come as a surprise, but I agree with you on that.

I personally am quite worried about basing our health insurance system on the backs of employers. It seems to me that increasingly we have this problem that the recession has only been a catalyst to, which is that more employers are finding it very difficult in terms of cost to provide their employees with health insurance benefits. And increasingly we have a situation where there are many people who do not have health insurance simply because they work for either a very small employer or because the employer they work for has a workforce which is either older or predominantly female or for whatever medical underwriting reason has high premiums, relative to another employer which may make the same product and yet if that workforce is younger or more predominantly male, they face lower premiums. To me that is simply inequitable in terms of access to health care.

I would, however, give credit to Mr. Stark for at least trying on an incremental basis to provide health insurance to part of the population without health insurance. I do agree with Mr. Cardin that the unemployed uninsured are a small portion of all the people without health insurance, and there are many employed workers who don't have health insurance.

Mr. RUSSO. But isn't this the most expensive way of doing it?

Ms. SWARTZ. I don't know. To be perfectly honest, I do not know. But if you make a start and say that we have to have a program that is administratively efficient—and certainly Medicare is more administratively efficient—then maybe that is the approach. And if you want to have the middle-class brought into some kind of national system, then certainly the middle-class—the elderly middle-class is already in Medicare. Start with the unemployed uninsured, and then bring in employed uninsured, maybe that is the way to go.

Mr. RUSSO. Thank you. Do you want to make a comment on that?

Mr. CORSON. No.

Chairman STARK. Dr. Swartz, your response to Mr. Russo's question is music to my ear. Did you testify before the Pepper Commission?

Ms. SWARTZ. No.

Chairman STARK. That is too bad.

Ms. SWARTZ. They had lots of advice.

Chairman STARK. I thought I heard you suggest in your response to the previous question that the employment basis for providing medical care insurance is not a very efficient way to distribute the benefits. Is that a fair paraphrase?

Ms. SWARTZ. I am not sure that I would say inefficient, but I worry about the equity over the long haul. And I worry a lot about the United States moving down that road.

Chairman STARK. In worrying about equity, isn't one of the issues, for instance, who gets stuck with paying for the kids? I mean, which employer in a two-employee family? The average number of parents that a child has between birth and majority is, what, six in this country today? In spite of Dr. Sullivan's admonition. You know, it seems to me just an illogical system for distributing benefits to dependents, through the employment system. It would seem to have no relationship.

Would you concur with that?

Ms. SWARTZ. I certainly think there are problems with it. I worry more about the fact that if people feel bound to their current employer because of the health insurance, and if they have some kind of medical condition which would make them, therefore, have a pre-existing medical condition were they to switch jobs, and they don't switch jobs, I worry a lot about the productivity of the American workforce.

There are many aspects of this. Children is certainly one of them.

Chairman STARK. With two employed parents, what would be a logical, fair, sound, economic way to allocate the cost of the coverage of a dependent child as among two employers that you could write into a simple law or rule?

Ms. SWARTZ. Well, personally I would not do that. It seems to me that we know nothing right now about why a family chooses one parent's or the other's health insurance package to cover their children or the entire family. And without having a clue as to why they may do that, I would be very reluctant to mandate that one child who was born on an odd day of the month go with the father and the child born on the even day go with the mother.

Chairman **Stark**. We did it by birth weight and/or length of employment, and that didn't provide any more logical approach. And it really led us to say—and I think it was Mr. Russo—that we ought to have—I wish there was a better word, because "social" implicates something extremely liberal and non-conservative, but sort of a social base coverage. You just say all kids are insured. Now, it doesn't mean the employer doesn't have to pay something, but now all we have to argue about is who is going to pay for it in a social-based system. That seems to me to be the most efficient. I thought I heard you saying that, and I just wanted to see if I could get you to repeat that emphatically for the record to help Mr. Russo in his quest for universal health insurance.

Mr. McGrath?

Mr. **McGrath**. Thank you, Mr. Chairman. This is a good add-on to the briefing we had last week with Dr. Reischauer regarding this same subject.

My concern is certainly with the availability of health insurance for those who are unemployed. But, additionally, who is going to pay? How are we going to pay since, in this zero-sum game, we are going to have to find it from some means?

I am just wondering, Dr. Swartz, whether you find that people are taking advantage of COBRA continuity, although it may be expensive. Also, is it universally available to those who at one point had employment, and how effective is it or could it be.

Ms. **Swartz**. I think that we have very little evidence about how effective COBRA has been. We have had a hard time capturing who is purchasing health insurance directly because of COBRA. So all I really know is anecdotal evidence. And it seems to me that when you hear what the premiums are in total for many employers—that is, both the employee's and the employer's share, plus two percent—it is extremely expensive for most families. And what you hear anecdotally is that people may purchase it for a month or two if they know they are going between employers. But if they have lost their job—actually, I think Walt could talk to this more—I think they are far less likely to purchase health insurance for a period of time under COBRA because they have got to save their resources.

Mr. **Corson**. I don't know how many purchase insurance under COBRA, but the individuals we interviewed reported that their family incomes were low—50 percent reported that their family incomes were below $20,000 before they got laid off. So it seems unlikely to me that those individuals could afford insurance through COBRA.

Mr. **McGrath**. Is there any relationship here between those who are laid off from small business as opposed to large business? Does the limited tax exclusively for single employers of 25 percent of the cost of health insurance as opposed to the dollar-for-dollar deduction that large corporations are allowed to take for the provision of benefits to their employees have any effect?

Ms. **Swartz**. Do you mean in relationship to COBRA——

Mr. **McGrath**. No, no. In the Tax Code, we allow single employers to take a 25 percent deduction for their health insurance costs.

I am not sure where all these jobs are going or where these unemployment statistics are occurring. But if we provided the same kind of dollar-for-dollar deduction as large corporations get for their employees as opposed to what single employers get for themselves and perhaps other employees in their family, would this be part of a solution to the problem?

Ms. SWARTZ. I think it would certainly help. There is no question that if you had more of a tax deduction you might be more likely to provide health insurance to your employees.

Mr. McGRATH. Let me ask you just one further question. Given the fact that we are playing this revenue-driven zero-sum game, do you have any suggestions as to how an incremental addition of the unemployed to Medicare might be financed? It is easy to say we will just increase the HI wage base. We just did that, to $125,000. I am just wondering where we have to go in order to accomplish this aim and whether or not it is doable.

Ms. SWARTZ. I have not thought enough about how you would fund this particular expansion of Medicare. My own preference is for a national health insurance system that is funded through the personal income and corporate income tax system.

Mr. McGRATH. You and Marty Russo.

Okay. Thank you.

Chairman STARK. Are there other members who would like to inquire further? If not, I want to thank the panel very much for their contribution to today's hearing, and ask our second panel to come forward.

We are going to welcome Dr. Knut Ringen, the executive director of Health and Safety Fund of North America of the Laborers' International Union of North America. Dr. Ringen is accompanied by Kathy Conlan. Ms. Victoria Cook Bambaugh, the president of Local 31-M of the Service Employees International Union; and Mr. Charles Huston, vice president for Government Relations of Lukens, Inc., on behalf and representing the National Association of Manufacturers.

We will ask each of you to proceed in the order you were recognized, and at the conclusion the members will inquire.

Dr. Ringen.

STATEMENT OF KNUT RINGEN, PH.D., EXECUTIVE DIRECTOR, HEALTH AND SAFETY FUND OF NORTH AMERICA, ON BEHALF OF ANGELO FOSCO, GENERAL PRESIDENT, LABORERS' INTERNATIONAL UNION OF NORTH AMERICA, AND COCHAIRMAN, LABORERS' HEALTH AND SAFETY FUND OF NORTH AMERICA; ACCOMPANIED BY KATHLEEN CONLAN, LABOR ECONOMIST

Mr. RINGEN. Mr. Chairman, members of the committee, thank you very much for holding these hearings and allowing us to testify here today. My name is Knut Ringen. I am the executive director of the Laborers' Health and Safety Fund of North America. I appear before you today on behalf of Angelo Fosco, who is the general president of the Laborers' International Union. Mr. Fosco is recovering from illness and could not be here and asked me to convey to you his appreciation for these hearings.

With me today is Kathleen Conlan, who is a labor economist with us and who will be able to answer some of the questions that you raised with the earlier panel.

We have prepared an extensive written testimony that we would like to submit for the record and simply take a few moments to summarize that here.

Chairman STARK. Without objection, all of the witnesses' prepared testimony will appear in the record in their entirety.

Mr. RINGEN. The Laborers' International Union of North America represents over 500,000 members in the United States and Canada. We have 154 health insurance plans for our construction workers. In addition, our Mail Handlers Health Plan covers 1.2 million Federal employees.

We are acutely aware of the national health care crisis right now. These are bankrupting workers in the United States. An average blue-collar worker can expect to spend between 20 and 25 percent of his or her annual income on health care now, more than rent in many cases, and it is an absurdity. Health insurance plans like ours are right now facing over 20 percent annual inflation rates, and it is a serious crisis for them, too. Clearly we have to address these issues.

Unemployment is a particular issue of concern to us. Construction workers face unemployment continuously. The day they start a new job building something, they also start working themselves out of a job. Once you are finished building a bridge or a road or a house, once that is completed, you are out of a job and you go looking for a new one. So unemployment is chronic among our members, but it is usually fairly short term. And for 40 years, ours and other construction unions' health insurance plans have provided health coverage during unemployment and have done so very well.

Now with the recession, coupled with the runaway medical inflation that we are facing at the present time, we are in serious trouble. We are cutting back benefits for both employed and unemployed workers, while increasing contributions from employers into the plans very dramatically. This is a critical situation. It started in New England about a year ago, and it is spreading across the country, and we don't know what to do about it.

Americans without health care coverage are largely employed but don't receive health coverage through their employers, or they are unemployed. Right now the cost of covering health care for these people who don't have health care coverage ends up resting on existing health insurance plans through a transfer payment of one sort or another. This costs our members roughly 28 cents per hour and is rising rapidly.

In terms of unemployment and health, we are obviously very concerned first and foremost that unemployment leads to very serious health problems for people; but, secondly, it also leads to very poor health care. It leads to episodic care, to care in emergency rooms and clinics, to a lack of continuity of care, to late-stage diagnosis, ineffective treatment and poor outcomes. Something has got to change in that regard.

Our position on national health care is very clear. We have established this during three years of meetings with delegates from across the country. One, we have concluded we need Federal legislation now. Two, we believe that that legislation at this point should be mandated employer-provided health insurance, and that there should be basic benefit packages designed and cost control measures put in place. We don't oppose a Canada-type solution for the United States, but we don't think it is realistic at the present time.

In terms of coverage for the unemployed, we have concluded that COBRA has not worked, certainly not in our plans and certainly not for our members, and an alternative needs to be found.

As I said, we already provide coverage during short-term unemployment, usually from three to 12 months, as well as during extended disability. But a better system for providing unemployment coverage is needed. We believe that a voucher tied to unemployment insurance would be the best way. This voucher would be used to continue the basic coverage in existing employer-provided health insurance plans for the duration of the eligibility for unemployment coverage. This voucher would provide for the basic benefit package, either as defined by Medicare or some other mechanism, and the voucher would be funded out of existing unemployment trust funds. If an employee does not belong to an existing—or if the employer does not have a health insurance plan, that voucher could certainly be used to pay for Medicare coverage, for instance.

Our approach is not dissimilar to the one proposed by the chairman; but rather than pull people out of existing systems and into Medicare, we propose to allow people to maintain existing health patterns as fully as possible and to strengthen those patterns. But changing a plan in midstream, as is proposed, is a bureaucratic nightmare or could be a nightmare, and it would be difficult to continue health care patterns under this situation. And to ask people to pay for coverage when they can least afford it during unemployment seems to be a major disincentive.

In summary, we have found that health insurance historically has developed incrementally in the U.S. To resolve the problem of health insurance for the unemployed would be a significant step forward. Our trusts have been providing such coverage for a long time. We believe that all employers should be required to provide health insurance coverage, and that that system should be extended to the periods of unemployment that people face, and that the best way to do it, as I have proposed, is through this voucher mechanism tied to the unemployment compensation system.

We will be pleased to answer any questions that you have. Thank you for letting us testify here today.

[The statement of Angelo Fosco as presented by Mr. Ringen follows:]

STATEMENT OF ANGELO FOSCO, GENERAL PRESIDENT, LABORERS' INTERNATIONAL UNION OF NORTH AMERICA, AND COCHAIRMAN, LABORERS' HEALTH AND SAFETY FUND OF NORTH AMERICA

Good morning, Mr. Chairman and members of the Committee. My name is Angelo Fosco. I am General President of the Laborers' International Union of North America and Co-Chairman of the Laborers' Health and Safety Fund of North America, a joint labor-management program. Thank you for inviting me to speak today about our union's insights into health insurance for the unemployed. Accompanying me is Dr. Knut Ringen, Executive Director of the Laborers' Health and Safety Fund, and Kitty Conlan, Labor Economist for the Fund.

The Laborers' International Union N.A. and Health Care

The Laborers' International Union of North America (LIUNA) represents some 500,000 members in the United States and Canada, the vast majority in the United States. In the United States, health insurance is provided directly or arranged for the union's members and their dependents by 154 health and welfare trusts; these are jointly trusteed by representatives of the union and management. In addition, the union's Mail Handlers Benefit Plan serves a total of 1.2 million federal and postal employees and their dependents. (Eighteen jointly trusteed Canadian health and welfare funds supplement national health insurance in that country.)

LIUNA has arranged for or provided health insurance for its membership for 40 years. However, knowing that health insurance alone cannot solve the membership's health-related problems, the union established what is now the Laborers' Health and Safety Fund of North America (the Fund).

The Fund was mandated by the LIUNA 1986 International Convention as a "national occupational health and safety fund" to research the causes of the health problems of the members and their families, and "promote the health and safety of our workers." The Fund also was designated to deal with the spiraling health care costs that threaten the financial viability of our health and welfare (health insurance) trusts, and help employers to comply with health and safety regulations.[1]

The Unemployed and the Health Care Crisis

We greatly appreciate your efforts, Mr. Chairman, over many years to address the needs of working people.

The health care crisis is crippling our members financially. With health insurance premiums rising at almost 20 percent per year, the health care industry is totally out of control. Many of our health and welfare trusts are being threatened by bankruptcy.

Assuring that the unemployed have access to health care has long been one of our concerns, for several reasons.

The Nature of Construction

Unemployment is a way of life for construction workers. When our members start work on a new project, they immediately start to work themselves out of a job[2]. Unemployment rates in construction are twice the average for the U.S. workforce as a whole. To address this problem, over 40 years ago, our health and welfare trusts began to provide coverage during periods of unemployment.[3] However, unemployment rates in construction are increasing faster than the plans can keep up with. In New England, for instance, coverage for the rapidly increasing number of our members who now are unemployed is posing a fiscal crisis to our trusts. In order to sustain coverage, benefits for both actively working members and unemployed members have had to be cut back, while contributions from employers have had to be increased dramatically.

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[1] The Fund was founded in 1988 as the Laborers' National Health and Safety Fund. The name was changed in 1990 to accommodate the development of a Canadian program.

[2] We estimate that construction workers are employed 1,500 hours yearly, which is 72 percent of the time for those employed in industries with a 40-hour work week.

In spite of these efforts, especially with the recession and the anti-union climate of the past decade, many unionized construction workers have been unemployed for longer periods, outlasting their benefits coverage.

Uncompensated Care

Through surcharges of one form or another, our health and welfare trusts must subsidize health care for the uninsured, who include the unemployed and their dependents.[4] Most non-union construction employers do not provide health coverage, and thus our health and welfare trusts also end up being charged in part for their health care.

In recent years, given the rapidly rising health care premiums and the competitive pressures of the marketplace, many employers have felt unable to continue to provide costly medical insurance. Union employers, however, have been responsible enough to continue to insure their employees and dependents.

However, declining access to insurance on the job, of course, has increased the burden of uncompensated care.

In New Jersey, for instance, we identified a tax for uncompensated care of up to 23.4 percent, which is added to hospital bills paid by insurance providers such as our health and welfare trusts. With our local unions, we have been actively involved in the debate there about how to resolve this problem. Two reports we have prepared on this matter are attached (**attachments 4 and 5**).

The costs of uncompensated care eat into our members' wage gains and other benefits, and penalize responsible employers. As things stand now, our contractors are left at an increasing competitive disadvantage.

Unemployment and Health

Unemployment contributes to health care costs in two ways. The pioneering work of Dr. M. Harvey Brenner of the Johns Hopkins School of Public Health, and other research, has made clear the devastating health effects of unemployment. It places families under stress and creates health problems. Also, lack of health care coverage during unemployment leads to episodic care, including late-stage diagnosis, and crisis management, which is ineffective medically and very costly to individuals and society.

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[3] For instance, in one typical plan, a member who has worked 250 hours in one quarter will be eligible for coverage in the following quarter, even if he/she is unemployed. In some plans, eligibility for continued coverage may extend longer, depending on the plan design.

[4] The Subcommittee on Health estimates that half of the 20 million Americans expected to be unemployed at some time during this year will be eligible for unemployment compensation. Two-thirds of those on unemployment will obtain coverage through their spouse's employer, COBRA or another source, leaving roughly 3.3 million uninsured and on unemployment compensation. COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, which allows some former employees to continue medical insurance coverage at the employer's group rate for 18 months or longer.

Given these concerns, the Laborers' Union and the Health and Safety Fund have developed procedures and proposals which we believe can help solve much of the dilemma facing this panel today.

National Health Insurance

We see an urgent need for national health insurance legislation. Ours is the only industrialized nation, except South Africa, that does not have a national health insurance program.

Universal access to basic health care is not only humane; it makes good financial sense. The uninsured, for the most part, do not benefit from the widely touted top-quality health care available in this country. As long as a large part of our population does not have access to cost-effective, basic health services, we cannot hope to control this nation's rapidly escalating costs of health care delivery.

The Laborers' Position

For the past two years, leaders of this union have debated and refined a proposal for national legislation, which is attached (**attachment 1**; also see **attachments 2 and 3**). It calls for mandated employer-provided insurance for all employees and their dependents, with a requirement that employers who do not provide insurance pay into a pool. That pool, combined with other federal funding, such as an extension of Medicare, would insure all others--the unemployed, children, the elderly, the disabled and so on. Such a program, of course, must provide for cost controls.

After extensive debate, we decided to support this approach instead of a Canadian type of "single-payer" program because it is less costly, less disruptive, and the most practical. Employer-based health care would build on the strengths of our nation's existing privately based medical system.

At the same time, this system would allow more flexibility to provide for the urgent, special health needs for our members (and for other construction workers).

Thus, for the long term, we think the solution to the problems touched on here, such as uncompensated care, is a basic package of federally mandated employer-provided health care. Health needs don't know state boundaries. Providers and the public need a consistent health care delivery system, which can be obtained only through federal legislation. Financial incentives for preventive health care and cost control can be built in.

The Solution

A key to our approach is to build better systems to reduce the episodic nature of health care in America. Even our members, with their health insurance coverage, have tended to use emergency rooms, which is not effective or efficient. We are trying hard to put in place systems to reduce this pattern. Building continuity of care is probably the most critical improvement we can make in terms of health care for vulnerable groups in our society.

One of the biggest disruptions to ongoing care is unemployment.

We need to build systems to reduce this disruption, as well.

It is clear that COBRA has not achieved its intended effects. Even at group rates, health insurance costing hundreds of dollars, is out of the reach of most unemployed.

Our Approach: The Voucher

Our proposal for health care coverage for the unemployed builds on the basic proposal of mandated, employer-provided insurance.

To allow for continuity of basic health care for those suffering unemployment, we propose using vouchers equivalent in value to the basic health care benefit package, adjusted for regional variations. This voucher would be provided to all persons who apply for and receive unemployment compensation, and would remain in effect for the duration of eligibility for unemployment coverage. The voucher would be funded out of existing unemployment insurance trust funds, and would be financed through unemployment insurance revenues. The voucher system would allow the unemployed to continue participating in the medical insurance group maintained by the previous employer or, in the case of construction, by the health and welfare trust. If the employer did not provide health coverage, the voucher could be used to buy into Medicare coverage.

The voucher system resembles your proposal, Mr. Chairman, to allow those qualified for extended unemployment benefits to participate in Medicare. Two fundamental differences are proposed however. First, we aim to enable a worker to continue his or her existing coverage. This helps maintain continuity of care and uphold the financial stability of the health and welfare trust. Second, we believe that health coverage costs should not be placed on the individual worker as is proposed in the existing legislation, at the time when he or she can least afford it. COBRA has proved that this does not work.

A number of additional factors would have to be considered, of course: how to be sure that such vouchers only go to those without alternative sources of insurance, if the government pays all or part of the insurance cost, what to do about the unemployed who use up their unemployment compensation benefits (We suggest they be provided care the way all others not receiving insurance through an employer).

Health Insurance for the Unemployed: Part of the Solution

These hearings address a particular issue, one part of the problem. Addressing the need to assure health care access for the unemployed does not obviate the need for overall health care reform, including effective health care cost control policies.

However, health insurance in the United States historically has developed incrementally. To resolve the problem of health insurance for the unemployed would be a significant step forward.

The multi-employer health and welfare trusts, particularly in construction, have been unique in that they have provided coverage, within reason, for workers during unemployment. We believe all employers should be required to provide health insurance coverage, and that the system of providing insurance as part of unemployment compensation would extend to all employers the responsibility that union employers in construction have met for 40 years.

Attachments

1. Laborers' Health and Safety Fund. Resolution on the Need for National Health Care System Reform.

2. Angelo Fosco, "The Cost of Doing Nothing About Health Care Reform," NCCMP Update (National Coordinating Committee for Multiemployer Plans), Spring 1990.

3. Laborers' Health and Safety Fund. A Strategy on the National Health Care Crisis. Feb. 7, 1990.

4. Howard S. Berliner, Sc.D. Payment for Uncompensated Hospital Care in New Jersey: Impact on Union Health and Welfare Funds. Laborers' Health and Safety Fund, March 1989.

5. The New Jersey State (Laborers') Health and Safety Trust Fund. The State of Health Care Reform in New Jersey: The Funding of Uncompensated Care. December 1990.

Chairman **Stark**. Thank you.

Ms. Bambaugh.

STATEMENT OF VICTORIA COOK BAMBAUGH, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 31-M, DETROIT, MI, ACCOMPANIED BY NED McCULLOCH, SENIOR LEGISLATIVE REPRESENTATIVE, SEIU

Ms. **Bambaugh**. Good morning. My name is Victoria Cook Bambaugh, and I am president of Local 31-M, and we are of the Service Employees International Union. I am joined today by Ned McCulloch, who is the senior legislative representative from SEIU. Our local represents currently over 1,500 members in the State of Michigan. Mr. Chairman, I would like to have said that it was 31,000 when you first introduced our local as 31-M. We used to have a local of approximately 6,000, and we are now down to about 1,500. Our local itself has felt the pinch in many layoffs.

On behalf of SEIU and its 950,000 members, I thank you, Chairman Stark, and other members of the subcommittee for the opportunity to testify on your effort to extend Medicare to the long-term unemployed. In our State of Michigan, and elsewhere, I am sure everyone is very much aware from newspaper articles, from TV stories, of the extremely long unemployment lines that are filled with individuals who have lost their health care insurance. Not only are they unemployed, but they have lost the insurance that is very necessary to them. My testimony today is about those people and their struggle to obtain affordable health care coverage while employed.

The bulk of our membership does represent people in the Employment Security Commission in Michigan. For Service Employees International Union, I chair what is called the Employment Service Work Group. We represent other local unions across the country that represent other employment security workers, and one of the most common questions that is asked of our membership when people come in to collect unemployment is: Well, if I am eligible for unemployment, where do I go for my food stamps? Do I go to DSS? My health care? I don't have health care coverage any more. Where do I go for that? Do I go to the Department of Labor? Do I go to the MESC? Do they provide it? Does DSS provide that along with food stamps? It is a consistent question that is constantly asked of our membership when people come in to file their unemployment.

SEIU's membership cuts across a wide spectrum of service occupations in both the public and the private sectors. The Service Employees International Union is the largest health care union currently in the United States and represents nurses, nurse's aides, and other workers in health care setting. Our union also represents public employees at all levels of government, building service workers, and various industrial and allied service workers. Many of our members face the prospect of layoffs during this service-driven recession.

H.R. 1492, the Health Insurance for the Unemployed Act of 1991, would assist those SEIU members and others struggling through the long-term unemployment. Members of my local work in the unemployment offices throughout Michigan. They observe firsthand the rising unemployment and the growing delays to get unemployment claims. The unemployment insurance system is under great strains as it struggles to provide partial wage replacements.

The problem is particularly severe for the long-term employed. For those families, the period without income has eaten away at family resources. They often are unable to pay for health insurance coverage despite its importance.

1990 layoffs currently have accounted for approximately 15 percent of the unemployed, according to the Bureau of Labor Statistics. This figure, though, I think should strongly be looked at and taken into consideration that that actually only accounts for those people out there that are currently collecting unemployment insurance.

Today I would like to relate at least four stories that we are familiar with from our union to help illustrate the problem. One is from Massachusetts, others from Michigan, Maine, and Rhode Island.

In Ware, Massachusetts, a member, Diane Dezielle, was laid off on March 4th after working as a lab technician for Tobey Hospital, a small acute-care institution. She has been the principal source of support in her family since her husband was laid off last year. Although Diane and her son have been healthy, her husband has a back condition that forced him to leave his previous job.

While Diane was working, her paycheck was $585 per week. Including her husband's benefits, the family budget totals $693 per week. Now that she is unemployed, the only income for the family of these three people will come from unemployment benefits—a total of only $390 per week.

Tobey Hospital will continue its contribution to the family's health insurance coverage through June. At that point, the Dezielles will face an impossible choice—the choice of either paying $497.04 per month to continue coverage, or to completely lose their health care insurance.

If they decide to continue to pay for coverage, a third of that family's budget will go for health insurance. If they decide to drop that coverage, they will lose almost 50 percent of more money that should be used for food, shelter, and clothing. But then what if a medical problem occurs for this family?

There is another situation, one that we have in Michigan. This situation is just as bad as in many other States. SEIU Local 526-M, which is based in Lansing, Michigan, represents the correctional officers at over 30 Michigan prisons. Their executive director, Fred Parks, recently received notice from the Governor that over 300 correctional officers will be laid off this April the 15th.

In the layoff notice, the State of Michigan included what they call a layoff or a reduction in force package. It is a two-page handout that detailed the health insurance options for the correctional guards. As mandated in this contract with the workers, the State offered to pay for the health insurance during the first four weeks after the layoff. During this initial period, the guard's obligation is limited to a premium payment of $22.50.

However, after the four weeks is up, the correctional guard must then start paying $487.50 per month to continue to receive that family coverage. Assuming the correctional guard is unemployed for the rest of the year, this premium payment for health insurance during the year of unemployment would be $5,850.

The family budget for the unemployed correctional officers will be under enormous pressure after the layoffs. The correctional officers will receive a maximum of $1,100 per month in unemployment benefits. The health insurance premium alone will devour almost half of the unemployment check, leaving only $612 for everything else—food, clothing, shelter, et cetera.

In Rhode Island, the State is now threatening to lay off approximately 100 employees, some of these employees having 17 years of seniority, and this is in the Department of Social Services. Although these members will be carried on the State plan for three months, by July they will be forced to pay again the entire cost of the health insurance or lose all coverages.

For these Rhode Island members, the monthly family coverage will rise to $398.87. Unemployment benefits for these families will be approximately $1,100 per month. Continuation of coverage will swallow up 36 percent of this family's budget.

These three States—Massachusetts, Michigan, and Rhode Island—are not being singled out because their problems are unique. Health insurance coverage is expensive throughout the United States. As we watch the annual rate of increase in the cost of health coverage shoot past the 20 percent mark, employers and unions both feel a deep sense of frustration.

Medicare coverage provides a sensible option for providing insurance benefits to the long-term unemployed. It would assist SEIU members in Michigan, in Maine, Rhode Island, and possibly Massachusetts. The Service Employees International Union supports the Health Insurance for the Unemployed Act of 1991.

However, we believe this bill must go hand in hand with overall unemployment insurance reform through passage of H.R. 1367, the Unemployment Insurance Reform Act of 1991. Only four States—Michigan, Rhode Island, Maine, and Alaska—have qualified for extended benefits despite a rising unemployment rate. Other States, such as Massachusetts, are at the edge of triggering the extended benefits.

Finally, it should be stated that while this bill fills a gap, Congress must act on national health care reform in order to provide access for all Americans.

Recently, the Executive Council of the AFL-CIO unanimously endorsed the health care reform plan recommended by the AFL-CIO task force, which was chaired by SEIU President John J. Sweeney. The council unveiled a pragmatic legislative agenda focusing on cost containment, universal access, and administrative overhaul.

Labor's 2-year, in-depth review process carefully weighed the effects of the health care crisis on collective bargaining negotiations, health and welfare funds, and the needs and interests of union members and all Americans.

A key to the plan is the establishment of a national cost-containment program that would save $165 billion by the end of the decade. The cost-containment measures, along with the guaranteed right of all Americans to a core package of health care, forms the basis for establishing the essential Federal safety net.

To close, the Service Employees International Union supports H.R. 1491, the Health Insurance Act of 1991, and urges this committee to enact it along with broader health care reform.

I thank you for the opportunity to speak to you today, and we would be happy to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT OF VICTORIA COOK BAMBAUGH, LOCAL 31-M, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Good morning. My name is Victoria Cook Bambaugh and I am the President of Local 31-M of the Service Employees International Union. My local represents over 1,500 employees of the Michigan Employment Services Department. On behalf of SEIU and its 950,000 members, I thank you, Chairman Stark, and the other members of the Subcommittee for the opportunity to testify on your effort to extend Medicare to the long-term unemployed.

In Michigan, and elsewhere, unemployment lines are filled with individuals who have lost their health insurance coverage. My testimony today is about those people, and their struggle to obtain affordable health care coverage while unemployed.

SEIU's membership cuts across a wide spectrum of service occupations in both the public and private sectors. The Service Employees International Union is the largest health care union in the United States and represents nurses, nurse aides and other workers in health care settings. Our union also represents public employees at all levels of government, building service workers, and various industrial and allied service workers. Many of our members face the prospect of layoffs during this service driven recession.

H.R. 1492, The Health Insurance for the Unemployed Act of 1991 would assist those SEIU members and others struggling through long-term unemployment. Members of my local work in the unemployment offices throughout Michigan. They have observed first-hand the rising unemployment and long delays of 4 to 6 weeks to get unemployment claims. The unemployment insurance system is under great strains as it struggles to provide partial wage replacements.

Thanks to this committee's work on the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an employee who is terminated, or whose hours are reduced, is eligible for continuation of health insurance offered at the workplace if the firm employs at least 20 workers. This coverage must be offered at cost by the former employer to the layed off employee plus a small administrative fee. Through continuation of coverage, the layed off employee obtains insurance at the employers group rate.

In 1990, layoffs accounted for about 15% of the unemployed, or about 1,074,750 unemployed individuals, according to the Bureau of Labor Statistics.

Unfortunately, many of the unemployed can not afford health insurance coverage despite the option provided by COBRA. COBRA premiums averaged over $3,000 per employee in a recent survey by Charles Spencer and Associates. 25% of those eligible under COBRA (which includes broad categories of workers and dependents) maintained their health insurance coverage. The percentage of layed-off eligibles that maintain health insurance is likely to be much smaller. The simple fact is that many persons on lay-off can not afford COBRA coverage even at the group rate.

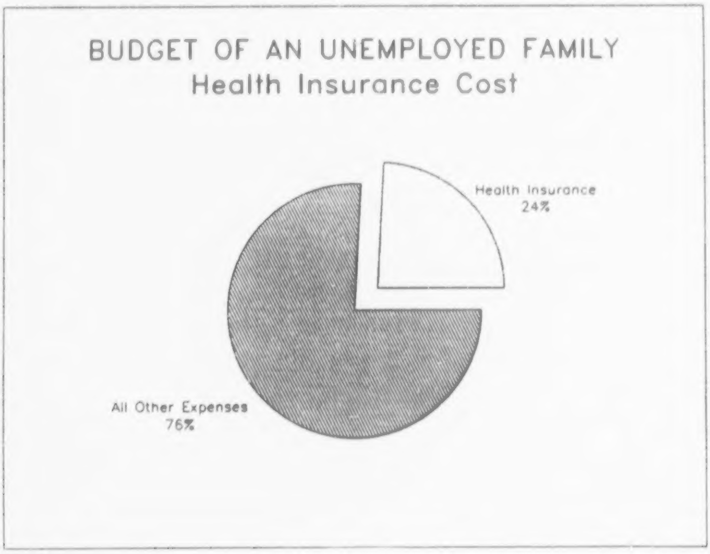
The problem is particularly severe for the long-term unemployed. For those families, the period without income has eaten away at family resources. They often are unable to pay for health insurance coverage despite its importance.

I would like to relate four stories from our union to help illustrate the problem -- one from Massachusetts, and others from Michigan, Maine, and Rhode Island. In Ware, Massachusetts, Diane Dezielle was layed off on March 4th after working as a lab technician for Tobey Hospital, a small acute care institution. She has been the principle source of support in her family since her husband was laid off last year. Although Diane and her son have been healthy, her husband has a back condition that forced him to leave his previous job.

While Diane was working, her paycheck was $585 per week. Including her husband's benefits, the family budget was $693 per week. Now that she is unemployed the only income for the family of three will come from unemployment compensation -- a total of $390 per week.

Tobey Hospital will continue its contribution to the family's health insurance coverage through June. At that point, the Dezilles will faced the impossible choice -- pay $497.04 per month to continue coverage or lose their health insurance.

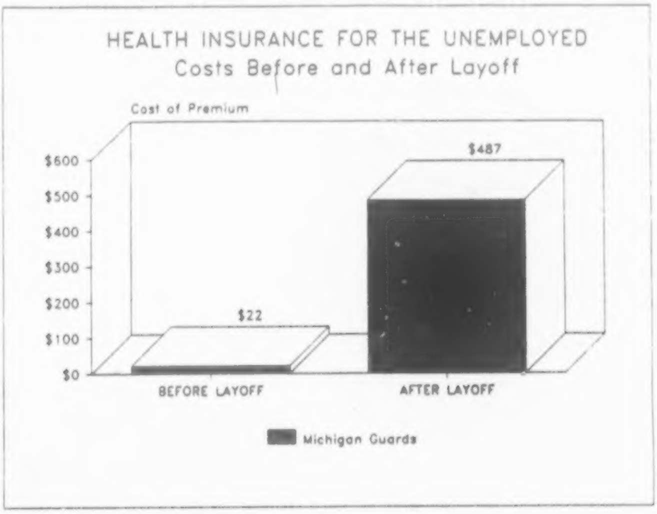
If they pay for continued coverage, a third of their family budget will go for health insurance. If they drop the coverage, they will have almost 50% more money for food, shelter, and clothing -- but what if a medical problem occurs.



The situation is just as bad in other states. SEIU Local 526 M based in Lansing, Michigan represents the correctional workers at over 30 Michigan prisons. Their Executive Director, Fred Parks, recently received notice from the Governor that over 300 prison guards will be laid off on April 15th.

In the layoff notice, the State of Michigan included a two-page handout that detailed the health insurance options for the unemployed guards. As mandated in the contract with the workers, the State offered to pay for the health insurance during the first four weeks after the layoff. During this initial period, the guard's obligation is limited to a premium payment of $22.50.

However, after the four weeks is up, the guard must start paying $487.50 per month to continue receiving family coverage. Assuming the guard is unemployed for the rest of the year, his premium payment for health insurance during that year of unemployment will be $5,850.



The family budget for the unemployed Michigan guards will be under enormous pressure after the layoffs. The guards will receive a maximum of $1,100 per month in unemployment benefits. The health insurance premium alone will devour almost half of the unemployment check leaving only $612 for everything else.

In Rhode Island, the state is threatening to lay off 100 employees with up to 17 years of seniority in their Social Services Department. Although these members will be carried on the state plan for three months, by July they will be forced to pay the entire cost of the health insurance -- or lose all coverage.

For these Rhode Island members, the monthly family coverage will rise to $398.87. Unemployment benefits for these families will be approximately $1,100 per month. Continuation of coverage will swallow up 36 % of the family budget.

Given the unaffordability of COBRA coverage, there are few alternatives to the unemployed. If they are lucky, they can pick up coverage through a working spouse. But most layed off workers go without.

These three states, Massachusetts, Michigan, and Rhode Island are not being singled out because their problems are unique. Health insurance coverage is expensive throughout the United States. As we watch the annual rate of increase in the cost of health coverage shoot past 20 percent, employers and unions feel a deep sense of frustration.

For families such as the Dezielles in Massachusetts, the situation is more frightening. Diane's health insurance coverage through the hospital was a essential component of the family budget. Unemployment in their home town is over 17% and has been high for several years. Although both parents have worked steadily in the past, unemployment places immediate financial pressure on the family. They will be forced to choose between health insurance, and food, shelter, and clothing.

In this context, H.R. 1492, The Health Insurance for the Unemployed Act of 1991 is a step in the right direction. It replaces expensive COBRA coverage with affordable insurance under Medicare at a time with families have few financial resources. Recipients of extended unemployment benefits rarely use COBRA coverage. Without coverage by Medicare, the families will often postpone needed medical treatment or use inappropriate services such as emergency rooms for non-emergency treatment.

Medicare coverage provides a sensible option for providing insurance benefits to the long-term unemployed. It would assist SEIU members in Michigan, Maine, Rhode Island, and possibly Massachusetts. The Service Employees International Union supports the Health Insurance for the Unemployed Act of 1991.

However, this bill must go hand in hand with overall unemployment insurance reform through passage of H.R. 1367, The Unemployment Insurance Reform Act of 1991. The present Insured Unemployment Rate (IUR) trigger does not adequately capture increases in long-term unemployment. As a result, only four states Michigan, Rhode Island, Maine, and Alaska, have qualified for extended benefits despite a 6.5% unemployment rate. Others, such as Massachusetts, are at the edge of triggering the extended benefits.

Finally, it should be stated that while this bill fills a gap, Congress must act on national health care reform to in order to provide access for all Americans.

Recently, the Executive Council of the AFL-CIO unanimously endorsed the health care reform plan recommended by the AFL-CIO task force chaired by SEIU President John J. Sweeney. The Council unveiled a pragmatic legislative agenda focusing on cost containment, universal access, and administrative overhaul.

Labor's two year, in depth review process carefully weighed the effects of the health care crisis on collective bargaining negotiations, health and welfare funds and the needs and interests of union members and all Americans.

A key to the plan is the establishment of a national cost-containment program that would save $165 billion by the end of the decade. The cost-containment measures, along with the guaranteed right of all Americans to a core package of health care, forms the basis for establishing the essential federal safety net.

To close, the Service Employees International Union supports H.R. 1492, The Health Insurance Act of 1991 and urges this Committee to enact it along with broader health care reform.

Chairman STARK. Thank you very much.
Mr. Huston.

STATEMENT OF CHARLES L. HUSTON, VICE PRESIDENT, GOVERNMENT RELATIONS, LUKENS INC., COATESVILLE, PA, ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS [NAM], ACCOMPANIED BY GORDON RICHARDS, ASSISTANT VICE PRESIDENT, ECONOMIC ANALYSIS, NAM; AND SHARON CANNER, ASSISTANT VICE PRESIDENT, INDUSTRIAL RELATIONS, NAM

Mr. HUSTON. Thank you, Mr. Chairman and members of the Health Subcommittee. I am Charles Lukens Huston III, vice president of Lukens in Coatesville PA. Accompanying me is Gordon Richards, NAM's assistant vice president for economic analysis, and Sharon Canner, NAM's assistant vice president for industrial relations. Lukens Inc. is a multi-industry Fortune 500 company. Its subsidiaries provide plate steels, pipe-coating and other services. Our company employs over 3,900 people and has operating facilities in 24 States. Adding together workers and our retirees, we provide health coverage to approximately 12,000 individuals at a 1990 cost of approximately $21 million.

I am pleased to appear on behalf of the National Association of Manufacturers' over 12,500 member companies, 8,500 of whom have fewer than 500 employees. The issue of access to care for some 33 million persons without coverage and rising costs of health care are of major concern to NAM.

The topic of this hearing, unemployment and health care coverage, is a natural concern, particularly in areas of this country with increasing unemployment. We believe, however, that new legislation is not warranted. Legislation making those receiving extended unemployment compensation benefits eligible for Medicare is ill advised for several reasons. And I might add that we have only received a copy of this bill on Tuesday.

The current recession, according to many economists, is expected to sharply decline by early summer, with the unemployment rate likely to peak in June at seven percent or slightly less, and the rate falling to 6.5 percent by the end of the year. Declining inflation and interest rates are setting the stage for recovery. More detailed information on economic indicators is included in my complete statement, which I thank you for making a part of the permanent record of this hearing.

Businesses generally appear to be optimistic. In fact, our company is experiencing a pickup. From NAM's perspective, two-thirds of the 90 manufacturing firms surveyed February 9th at the NAM's semiannual board of directors meeting agreed that the recession would be shallow. Confidence in economic recovery is important. It leads employers to invest, rehire, and create new jobs.

As to the health policy aspects of the legislation, adding yet another beneficiary group to Medicare, whose yearly costs are rising 13 percent annually, would hasten the program's financial breakdown. At the same time ignoring the uninsured workers would be unfair.

Laid-off workers temporarily without health insurance have several options, including coverage under a spouse plan in the case of dual-wage earner families. Forty-four percent of families in the United States include two wage earners.

The Consolidated Omnibus Reconciliation Act, COBRA, was enacted in 1985 for the specific purpose of maintaining coverage between jobs. Indeed, the continuation of health insurance coverage was an explicit recommendation made by policymakers during the last recession in 1981-83. For that matter, in 1982 a far worse recession than now faces us, the average spell of unemployment lasted just over two months.

The National Association of Manufacturers is committed to pursuing health system reform by expanding access for the uninsured, seeking ways to control costs, and improving the quality of care. Efforts to single out special groups—in other words, the unemployed uninsured—is bad health policy and may well exacerbate the current health cost crisis.

Rather than piecemeal solutions, Congress should focus on broad system reform issues: an estimated 33 million persons without health care coverage, employer costs rising 20 percent yearly, and as much as 50 percent from some small firms, and problems of achieving a high level of health care quality.

To this end, NAM's various recommendations are contained in the full text of my statement. Due to time constraints, I would just mention a few:

To improve access, expand Medicaid bringing in all adults and children at the Federal poverty level and permitting a subsidized buy-in on a sliding scale up to 200 percent of poverty; provide special tax incentives for individuals and to small and start-up businesses to purchase health care coverage; and for small employers, improve access to coverage and affordability by reforming the small group health insurance market.

To control cost and improve quality, assure adequate budgets for Medicare and Medicaid to deter cost-shifting to the private sector; medical malpractice tort reform to reduce defensive medicine costs; and require State laws making hospital and physician data publicly available to assist purchasers in making informed buying decisions.

There are others in our recommendations, Mr. Chairman, but at this time I thank you for this opportunity to present NAM's view, and my associates from NAM will be pleased to respond to your questions.

[The prepared statement follows:]

Testimony of
Charles L. Huston
Vice President of Government Relations
Lukens Inc.
on
Health Care Coverage and the Unemployed
on behalf of the
National Association of Manufacturers
before the Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
March 21, 1991

Mr. Chairman and members of the Health Subcommittee, I am Charles Lukens Huston III, Vice President of Government Relations, Lukens Inc. Accompanying me is Gordon Richards, NAM's Assistant Vice President for Economic Analysis. Lukens Inc. is a multi-industry, Fortune 500 company. Its subsidiaries provide plate steels, pipe-coating services, cathodic protection services, heavy materials-handling equipment, industrial screening products and highway construction-zone safety products. Our company employs over 3,900 people and has operating facilities in 24 states. Adding together the dependents of those workers and our retirees, we provide health coverage to approximately 12,000 individuals at a 1990 cost of approximately 21,000,000.
Lukens is an active member of the National Association of Manufacturers' policy committees. I am pleased to appear on behalf of NAM's 12,500 member companies, 8,500 of whom have fewer than 500 employees. The NAM is pleased to appear before you today to present our views on health coverage and the uninsured.

The topic of this hearing, unemployment and health insurance coverage, is a natural concern, particularly in areas of this country with increasing unemployment. Upon further analysis, however, the economic indicators measuring the recession and the health policy aspects of the issue raise certain cautionary notes against legislative action to correct a problem which may be temporary in nature.

We understand consideration is being given to enacting legislation to provide Medicare benefits for laid-off workers (and their families) who are eligible for extended unemployment compensation benefits. NAM would oppose this piecemeal approach to addressing the uninsured problem for several reasons as this testimony will attempt to point out. Comments on this proposed legislation are general in nature, since the legislation has yet to be introduced (as of 3/18/91).

Extent and Nature of Current Recession

According to our estimates, the recession that began last summer will last through the second quarter of 1991. Declining inflation and interest rates will set the stage for the recovery. The inventory liquidation cycle characteristic of most postwar recessions will not be in evidence since inventories are now being kept tight relative to sales. Consumption spending will account for a larger share of the downturn, due to losses in purchasing power implied by higher inflation, increasing personal indebtedness, and the decline in housing prices. The decline in investment should be a bit milder than normal, due to increased spending on computers and office automation equipment. However, investment in structures, both nonresidential and housing, remains in an extended period of decline. The trade improvement will be much stronger than normal, due both to the low dollar and the fact that higher growth overseas will continue to raise demand for merchandise exports.

With respect to the magnitude of the downturn, we anticipate a peak-to-trough contraction in GNP of -1.7 percent. This is a bit milder than average; the mean peak-to-trough contraction for the eight previous postwar recessions was -2.6 percent. The peak unemployment rate, likely to occur in June, should be in the area of 7.0 percent, or slightly less. This again is somewhat less than the postwar average, where the peak rate of unemployment was 7.4 percent. Comparisons of unemployment rates are difficult, of course, inasmuch as this figure is influenced by the starting value. Another way of evaluating the impact on labor markets is the change in civilian employment. Here the postwar average has been -1.2 percent. For the current recession, we anticipate a -1.1 percent decline.

While the recession promises to be relatively mild, the recovery will be unusually slow by comparison with prior business cycles. This time, the rise in consumption that has typically driven postwar recoveries will be considerably weaker than usual, as consumers continue to adjust to weak growth in real incomes, excessive debt, and declining home values. Instead, the role of exports will be proportionally larger. This is a reversal of the normal pattern in which domestic demand drives the economy in the initial stages of an expansion, and exports only take over in the final years; this time industry is more likely to undergo a phase of export-led growth early on.

On this basis, we anticipate that the unemployment rate will fall gradually, to 6.5 percent by the end of the year (essentially, its current level) and 6.0 percent or less by the end of 1992, assuming a GNP growth rate of 2.6 percent that year. The total rise in civilian employment during the 18-month period (July 1991-December 1992) is likely to be 1.7 percent.

Regarding the recession, businesses generally are optimistic. Our company is seeing a pickup in orders. Two-thirds of the 90 manufacturing firms surveyed February 9 at NAM's semiannual board of directors meeting agreed that the recession will be shallow. As for recovery, well over half predicted "steady, but unspectacular growth." Confidence in recovery is important, leading employers to invest, rehire and create new jobs.

Employment and Health Insurance Coverage

The March 1988 Current Population Survey conducted by the U.S. Census Bureau reported in 1990 that 85 percent of Americans under 65 were covered by health insurance. Employer plans covered two-thirds of those under 65 and nearly three-quarters obtained coverage through their place of employment. Employment-based group health benefits are truly a success story from the employee's perspective, covering over 165 million Americans. Such benefits serve several important purposes--from assuring a healthy productive workforce, providing the emotional and financial security of family protection, to functioning as an employee relations tool in attracting and retaining quality workers. However, these benefits are quickly becoming unaffordable, as the demand for expanded coverage outpaces business profits and reduces business competitiveness by draining funds needed to upgrade and expand facilities. Some small firms become discouraged or financially unable to offer benefits altogether.

In particular, coverage for manufacturing firms is high. A January 1989 survey of NAM members revealed that of companies with fewer than 25 employees, 96 percent offered benefits to workers and 94 percent offered such benefits to dependents as well. For larger companies the coverage rates neared 99 percent. While some self-selection in the survey may have occurred, other studies, such as that conducted by the U.S. Small Business Administration, tend to confirm these numbers.

During times of economic downturns individuals temporarily out of work may have several alternatives. Dual wage-earner families present an opportunity for coverage under a spouse plan. In 1990, an estimated 44% of families had more than one wage earner.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more workers to make available health insurance to former employees and their dependents, including divorced spouses. Congress intended COBRA to act as a bridge for employees to maintain coverage between jobs. Coverage may be available for 18 to 36 months from the date of the qualifying event while disabled employees may be covered for up to 29 months. Typically, COBRA benefits expire when the COBRA beneficiary becomes covered under a new employer's plan. COBRA, however, has been costly to employers. A recent survey conducted by Towers Perrin indicated that all companies reported total COBRA claims costs exceeded total premiums paid by 183 percent in 1988, 67 percent in 1989 and 90 percent in 1990. COBRA is beneficiary-paid; however, employers may only charge 2 percent to cover administrative costs.

Historically, it is important to note that during the last recession (1981-83), considered significantly more severe than the present one by many economists, the full Ways and Means Committee held a hearing June 17, 1983 on health insurance and the unemployed. Then OMB Director David Stockman noted that lack of coverage among the unemployed was an issue of selective gaps and discontinuities and not a pervasive problem. He cautioned against a new entitlement program and instead offered policy reforms to fill temporary coverage gaps. Access to continued coverage and enrollment in a working spouse's plan were recommended, both elements of which are contained in COBRA. Subsequent amendments preventing loss of coverage due to a pre-existing medical condition and other enhancements have been added far beyond that envisioned by Mr. Stockman. Indeed, there is a significant safety net in place to assist the unemployed in obtaining health care coverage.

Improving Access for the Uninsured and Other System Reform Issues

Access. Based on the March 1988 Current Population Survey, the number of persons in the United States without any form of health insurance was 33 million persons. How the number of unemployed uninsured specifically adds to the number of employed uninsured is not clear, nor of major significance for that matter. More important is the overall problem of the uninsured. Many employed uninsured are low-wage workers employed by very small and often marginally viable firms. In fact, only 39 percent of those firms with fewer than 25 employees offer health insurance. (National Federation of Independent Business.) Ignoring the health care needs of the working uninsured and only helping laid-off workers poses a major question of equity.

The numbers of the uninsured have increased as government policies have limited access to coverage for those who should be covered by public programs. A case in point: two-thirds of uninsured workers earn less than $10,560 a year (the federal poverty line for a family of three); the median uninsured worker earns less than 150 percent of the federal minimum wage. Medicaid covers fewer than 40 percent of those persons living below the poverty line and because many states require income of less than 50 percent of the poverty level for Medicaid eligibility, few working people, even if low-paid, can qualify.

Cost. Our nation spent $601 billion on health care in 1989, up 11.1 percent from the previous year, while business spent $173.4 billion, up 12.3 percent over 1988. (Health Care Financing Administration).

A recent survey of medium and large employers (Foster-Higgins) revealed that costs rose 46.3 percent over the past two years. The United States spends far more than other nations on health care, thus diverting resources from other societal needs, undermining America's economic strength and competitiveness in the global marketplace. Inadequate provider reimbursement has resulted in massive cost-shifting to employers, while some employers are unable to obtain affordable coverage in the first place. Medicare costs are rising. Adding a new group of beneficiaries can only hasten Medicare's financial breakdown.

Quality of Care. Uneven quality and inappropriate care significantly add to the cost of health care. The Rand Corporation estimates that unnecessary and inappropriate care adds as much as 10 percent--or $50 billion annually--to health costs. Quality varies across the country; for example, residents of Boston are more than twice as likely to undergo a controversial stroke-preventing procedure as residents of New Haven, Connecticut. Additional studies by Caper and Wennberg of two Maine cities reached similar conclusions for hysterectomies.

A study of coronary bypass operations in one western state found 14 percent of such procedures were unnecessary. Nationally, 230,000 bypass operations were performed in 1987 at an average cost of $28,000. Eliminating inappropriate use of this procedure could save $1 billion annually.

Quality as measured by outcomes must be the primary concern. Once provider results are documented, purchasers and consumers can select the high-quality low-cost providers. Making purchasing decisions on the basis of quality must become the norm if we are to begin to gain some measure of control over cost.

The access, cost and quality problems of our health care system require reform in a coordinated manner. Attempting to solve one problem--i.e., health coverage for the unemployed--without attention to the others is likely to perpetuate the inadequacies and inefficiencies of the current system. Further, carving out a special group for receipt of Medicare benefits, even on a temporary basis, would exacerbate Medicare's budgetary problems. Moreover, Medicare's benefit design for the over-65 population may not suit the health care needs of this younger population group.

Short Term versus Long Term Solutions

As noted above, economic indicators point to a less severe short-lived recession. Given the slow pace of legislative action and subsequent regulatory followup, assistance may come too late for most persons. Historically, in similar debates in 1983, by the time the debate coalesced around specific legislation, the recession had ended. In 1982, the worst year for unemployment since World War II, the average spell of unemployment lasted just over two months.

Today, many members of Congress, including yourself, Mr. Chairman, in your introduction of "Mediplan," are attempting to look at access, cost and quality problems in a comprehensive manner. While NAM does not support a nationalized approach to these issues, we are an active player in attempting to devise broad solutions to this complex set of problems. NAM recommendations to improve access, control cost and improve quality are documented below.

In summary, we urge that the uninsured unemployed not be singled out as a special group for development of a new entitlement program and that COBRA, use of spousal coverage and other options be pursued to permit sufficient time to solve the access, cost and quality problem in a coherent and coordinated manner.

NAM Recommendations

To improve access, (1) expand Medicaid bringing in all adults and children at federal poverty and permitting a subsidized buy-in on a sliding scale up to 200 percent of poverty (or percentage of average per capita state income) for all others; (2) provide special tax incentives for individuals and to small and startup businesses to purchase health coverage and 100 percent deductibility for cost of medical benefits whether purchased by individuals, unincorporated or incorporated businesses; (3) for small employers, improve access to coverage and affordability by reforming the small group health insurance market.

To control cost and improve quality, (1) assure adequate budgets for Medicare and Medicaid to deter cost-shifting to the private sector; (2) enact medical malpractice tort reform at the federal level to reduce defensive medicine costs; (3) emphasize managed care in federal programs and in other appropriate federal legislation; (4) require states to enact laws making hospital and physician data publicly available to assist purchasers in making informed buying decisions; (5) continue research/implementation of practice guidelines to encourage quality medical care; (6) eliminate state legislative and regulatory barriers to cost management including restrictions on utilization review and managed care; (7) eliminate state laws requiring coverage of specific medical procedures/treatments and/or classes of providers and reform coordination of benefit rules; (8) fund undergraduate and graduate medical training through nonpatient care means and promote research and training in cost-effective primary health care delivery.

Chairman STARK. Thank you.

Mr. Huston, I want to ask you a couple of questions, if I may, about Lukens and their plan. What I think I heard you say is that you are covering about 12,000 employees, retirees, and dependents?

Mr. HUSTON. Yes, sir.

Chairman STARK. And if my math is right, at a little under $2,000 a year a head, that's $24 million. Can you estimate, what you think your unfunded liabilities are? Do you have an unfunded liability? Are you willing to share with us roughly the size?

Mr. HUSTON. No, sir, we do not have unfunded liability, but I would like——

Chairman STARK. You don't have one? You are covered, you say?

Mr. HUSTON. Yes, sir. But I would like to do this, if I might. On a company-specific basis, I would like to take your questions and respond to you within a 10-day period. I am speaking today actually on behalf of NAM.

[The following response was subsequently received:]

ESTIMATE OF LUKENS, INC., UNFUNDED LIABILITY FOR RETIREE HEALTH BENEFITS

Lukens provides health care and life insurance benefits for retired employees. Substantially all employees may become eligible for those benefits if they continue to work for the company until they reach normal retirement age. The company recognizes these costs, totaling $6.8 million in 1990, $5.7 million in 1989, $5.5 million in 1988, by expensing them as paid.

Currently, these benefits are expensed when cash payments are made. Beginning in 1993, the expense for these retirement benefits will be accrued over the employee service period until the employee becomes eligible to receive benefits.

The expense will be actuarially determined in a framework similar to the one used to measure pension benefits under a defined benefit plan. Calculations will require assumptions regarding future health care costs and discount rates to measure the liability on a present-value basis. Under the new method, the expense is anticipated to increase, but the company has not yet quantified the impact. In the year of adoption, we will have the option of recognizing the transition obligation or amortizing that amount over a period of up to twenty years. At this point, no decision has been reached on this implementation issue.

Chairman STARK. I understand that, but I have a hunch that among Fortune 500 companies, Lukens is not particularly unique. You share the same costs and problems that everybody does.

One of the things that I have tried to figure out is if we did go to some kind of a national health plan or payment plan is how that would relate to what you are currently providing. I have used Medicare only because you and I know what it does. I think that I could sell you Medicare, if you will, at about $1,000 for your under-65 employees a year.

Now, you would have to probably come up and go to Prudential and buy a medigap policy to equal the benefits you have now, and that is going to cost you another, say, $700–$800 a year. So what I would love for you to respond to later, if you can, is: If I offered you basically Medicare benefits with a $2,500 cap, first dollar care for kids, on the basis of $1,000 per under-65 adult or $1,800 for what you would class as family, plus the cost of what a medigap policy would cost. How does that relate to what you are paying now?

If you can analyze that for me, I think that Medicare could be a good buy, and probably a better buy than you are getting, or if you are self-insured, then you are able to handle it. But I don't know that. You can respond now if you want.

Mr. HUSTON. That is an interesting question. I would like the time to check that out with our benefits office.

[The following was subsequently received:]

Would Lukens prefer to purchase Medicare benefits rather than what the company currently provides?

Lukens' review of the cost implications of Rep. Stark's proposal to purchase Medicare coverage for the company's pre-age 65 retirees would be a less costly alternative than company-sponsored coverage. The current cost for pre-age 65 retirees is approximately $2,612 per participant (i.e. the retiree, their spouse and any eligible dependent are counted separately). Under Rep. Stark's proposal, Lukens' cost would be $1,842 per participant assuming that the hospital does not balance bill any additional charges above the Medicare allowable limit.

While this proposal would certainly be cost effective for Lukens, it would be a short-sighted alternative in that this arrangement would have broader implications for the remainder of the health care system. Artificially reducing the reimbursement for Lukens' large retiree population will only continue the cost-shifting by local health care providers as they endeavor to maintain financial stability. Effective legislation to contain health care costs must deal with the underlying causes of health care inflation.

Chairman STARK. As I say, I am curious, and I have explored that. I would ask the same question of Mr. Ringen. I get a sense that people who have trustee plans want to hang on to them because they are in control. But what I wonder is—and I would ask you the same thing—if I could provide you—and I use the figures of $1,800 for a family or $1,000 for an individual. You don't have to go back and crank in what you think a medigap policy would cost. There is a $2,500 out-of-pocket cap. How does that compare with what you are able to provide out of your Davis-Bacon plan. I guess that is what it is.

Mr. RINGEN. It is a Taft-Hartley plan.

Chairman STARK. Taft-Hartley.

Mr. RINGEN. It would be a great deal for us.

Chairman STARK. I beg your pardon?

Mr. RINGEN. It would be a great deal economically. We would pay for the same package easily between $3,000 and $4,000 a year. Probably more than that. So in that sense, financially it would be very good, and that is why our delegates to meetings said we don't object to a national federally financed and administered health program if it is politically viable to get it through. And we have concluded—or the delegates have concluded that--we have gone over this since about 1908 now, and we haven't been able to do it, and maybe we should start a little more incrementally. Now, there are some things that I would suggest to you——

Chairman STARK. My grandfather voted for it in 1883 in Germany.

Mr. RINGEN. Go back even farther. You know, the debate in Germany started before then.

The issue before you is absolutely right. If we could have a Federal program, we would be much better off financially. We have the most inefficient health system in the world. There is no denying that. We also have the system that provides both the best and worst quality of care in the Western world. So there are problems with quality. So we don't argue those things. The question is what is politically realistic.

We think if we could get all employers to provide health insurance like our employers have been doing for 40 years, that would be a first step. But that would still have to be coupled with a national program of health care cost control, and I think that cost control has to come through a HCFA-type rate-setting system.

Chairman STARK. It is not fair to Mr. Huston. He is providing benefits, and that raises his costs. One of these days Mr. Huston is going to make a deal with you and me to take money for his company, and then we'll have a package.

Mr. HUSTON. I just might respond, Mr. Chairman, that the fact is that costs are a major concern to us because of our margins. And we are competing internationally, as you know. But one of the things we do is use the benefits as a recruiting tool. And with a high-tech steel company, this is a benefit to us.

Chairman STARK. My time has expired.

Mr. RINGEN. If I can just mention one more thing?

Chairman STARK. Go ahead.

Mr. RINGEN. We have 18 health insurance plans in Canada that provide supplemental insurance to construction workers under the Canadian provincial health and national health care system. That works very, very well for our members. Exceptionally well because our plans provide the supplemental kind of coverage for the health needs that are unique to construction workers that the national plan does not provide. But the national plan picks up the high-cost items.

Chairman STARK. I would like to know more about that at some future time.

Mr. Gradison?

Mr. GRADISON. Mr. Chairman, I basically want to thank the panel for their excellent testimony. I would observe that in my mind there is implicit in some of the things that have been said by the panel an awareness of what Medicare doesn't do—that is, that many private plans are superior to Medicare. Medicare, for example, has about a $700 hospital deductible. It has no catastrophic benefits. There is a substantial monthly amount which has to be paid for the Part B premium. There are no outpatient prescription drug benefits and so forth.

As a result of this, I just want to say from where I am coming from that I was especially glad to hear reference to the idea of health vouchers. I think in the long run we would be better off to recognize that Medicare is not the ideal model for the method of financing health care for the population as a whole. I think all of our experience is that it has ended up with more hair-splitting and counting angels on the head of a pin than you could imagine about what is covered and what isn't and what is a reasonable reimbursement—and, oh, my God, you know. I mean, there is a lot to be said for giving a voucher of adequate size and then let the employee of low income purchase coverage either through their employer, if there is an employer offering a plan, or through a State program, as in Medicaid.

We often hear references, and we just did, to a Canadian national health plan. There really isn't a Canadian health plan. There is a series of provincial plans. The provinces don't have to participate. It took 25 years, roughly, before they all participated. It is a series of provincial plans. Nothing wrong with that. But that to me is one of the attractive features of the Canadian plan, that it recognizes that you can have a goal, as they do, of universality, of portability, and comprehensive coverage, and still have tremendous variations in the method of financing and in the method of health care delivery.

So I am mostly going through this to say that I am glad to see that in the context of a bill which is really an expansion of Medicare, we are hearing some kind words said for the voucher concept. That is all.

Mr. RINGEN. I would like to comment on that for a minute, if I may. First of all, I think that it is good to take into account the diversity of the country, and I believe that our health plans which are jointly trusteed by employers and the union representatives and—as I say, we have 154 of them in the U.S. alone—are very effective in terms of creating benefit packages that are responsive to the needs of the members and the employers as well.

At the same time, I should be under no illusion to tell you that these health plans by themselves can control health care costs in the U.S. We are under the gun. Costs are being shifted onto us by Medicare, by the Blues, by other plans. We have virtually no leverage in the medical market as such, and unless the Federal Government steps in and provides cost control in this market, we are going to be unsuccessful entirely in terms of stemming costs. And I believe that remains still the most critical problem at this time.

Mr. GRADISON. I agree with you that cost-shifting is a very serious part of this problem. It is not at all clear to me how the employer mandates which have been endorsed by many groups nationally would resolve that problem, because there still would be a powerful incentive for the employer, particularly the larger ones in geographic areas where they do have some market clout, to go out and get the best deal they can even if it results in shifting of costs. So I appreciate there are other pros and cons to employer mandates, but I don't think an employer mandate would totally deal with the problem of cost-shifting. To the extent that we reduce, or hopefully some day eliminate, the number of health uninsured, that is a major step, obviously, reducing, but it would not in my view eliminate the problem of cost-shifting. I guess that is what I would say.

As an example, in the State of Hawaii, they have had an employer mandate plan since 1974, but many of the hospitals—there aren't a lot of hospitals there, but some of the hospitals still are having difficulties, especially those that are under pressure to negotiate a low price in order to get the business of a particular insurance company or a particular employer.

Thank you. I really appreciate your testimony.

Ms. CONLAN. In response to your concern about what the result would be, we believe that an employer-based uniform system would be just one component of a major national reform. We could deliver that to you for the record, cost control, minimum preventive services within the various plans have to be taken into account. But we are very strong in believing that if you introduce a mandatory employer-based program, it is going to help alleviate the additional financial pressures that are being felt within our own health and welfare funds. This is especially true in the construction industry which is a notorious industry in the non-union sector for not providing health insurance because of the size of the employers and also the transient nature of the employees. Unless you have some uniform central process, like you do with unionized Taft-Hartley funds, these contractors have a difficult time providing health insurance. This is why in the unionized sector these employers are providing the responsibility of having insurance for their own employees. The union is taking the responsibility of actually deferring some of their wage gains to maintain adequate health insurance for their members. Yet at the same time, we estimate that about 20 cents of the hourly contribution that is put into our health and welfare plans goes to pay for our union contractors' competitors.

So we think that if you establish a level playing field and have some of the other non-contributors start paying for some of these costs, it is going to make it a fairer situation for our members and for our employers.

Mr. **Gradison**. I had the opportunity many years before I came here, when I was active in the investment business, to work with the laborers local in Cincinnati on the investment side of their funds. They had a pension fund and health and welfare fund. And I worked with a number of other Taft-Hartley funds during those years. I was frankly tremendously impressed by the way in which that structure actually operated in terms of the cooperation of the management representatives and the employee's representatives, with equal representation on those boards in managing those funds. I appreciate there are lots of industries that don't have that kind of a representation, that don't want it mandated upon them, and I respect that. But in those particular cases, at least in my observation, it worked extremely well because they had a common goal, which was, within the funds available, to provide the maximum benefits for the employees and their families. Also they would take a long view of it, not just for today, but to make sure that they didn't do things that were short term that might damage their employees, or the companies, for that matter, in the future.

Anyway, thanks.

Mr. **Levin** [presiding]. I guess I am next, and I will call on myself.

Mr. Gradison, Bill, you mentioned Taft-Hartley funds. About 25 years ago, I represented one of them. In those days, you could represent both employers and employees. The Laborers' Union was part of the fund in southeast Michigan. The hourly cost was 10 cents.

Mr. **Ringen**. Today it is about $2.50.

Mr. **Levin**. Exactly, 25 times. So a special welcome to all of you, and if I might say in particular to Vickie Bambaugh, who is here from Michigan. And if I might say a special hello to you, Mr. Huston, a distinguished activist in the steel industry.

Let me ask you a question, if I might. Maybe you want to take off your hat as a representative of an organization and just however you would like react. I was on the unemployment lines in Madison Heights two weeks ago tomorrow, talking to unemployed workers, and here were two instances that related to health insurance. And I would like you to give me your feeling as a sensitive person what might the answer be. One was a woman in her 50's, I would guess. She worked in the service industry under a contract that required a certain number of hours a week plus a certain number of consecutive weeks in order to be covered for health insurance. And her employer, the last week before she would become eligible, would reduce her hours. So that would end the consecutive number of weeks necessary for coverage. Then she would go back full-time and work all the number of weeks necessary but one, and then her hours would be reduced. And then she was laid off. So she never had health insurance.

Then I met a couple who were in their 50's. He is a tool and die worker who has not been able to hire directly, so he is hired through an employing agency, and he has been getting four or five dollars an hour—a tool and die worker—while the company for which he works pays the employing agency $7 an hour. There is no health coverage for him because he is hired through an intermediary that has no health coverage.

This has been going on for ten years. So the tool and die worker and his wife, as I remember it—I may not remember each detail exactly—she has done part-time work. And they are in their 50's, and they don't have any health coverage. So here you have two working units, right? Even if you raise the Medicaid threshold, they wouldn't be covered.

Now, these are three of the 37 million. What do we do? Your company covers its employees. They go to emergency rooms, and your company in the end pays for that because it is twice or three times the cost.

Nothing that is in your testimony I think is going to change this. So what do we do?

Mr. HUSTON. There are several questions in that one question. Again, individually I would be sympathetic, but since we are on the record, obviously it is very difficult to respond to specific instances. I wish I had an answer for that. I really don't.

Mr. LEVIN. We face not the data but the people, right? And there is a problem with every system, every proposal. And I just mention this to you because your company has taken the lead in many, many respects and helped to transform an industry. And I hope that the larger companies learning from their own experience can give us guidance as to what we do as we face the uninsured. Because your company pays for the lack of coverage of millions through taxes or whatever it is, cost-shifting.

Does anybody want to comment on that?

Ms. CANNER. I am Sharon Canner on behalf of the NAM. We have recommended expansion of Medicaid or some other type of public program, recognizing that we are talking about a significant amount of money. We are not here to talk about how to finance that today, however, but really to make the statement that this is an issue that many people in this country and the Congress feel strongly about. It is an issue that we need to work on a solution together.

Mr. LEVIN. So expanding Medicaid wouldn't help these people.

Ms. CANNER. Well, what I am saying is Medicaid and some type of buy-in for Medicaid above the poverty level up to a certain percentage. We need to try to start to fill the gap. The NAM does not support the type of program that Mr. Stark or Mr. Russo have recommended, but we are talking about trying to have some type of public program—maybe we won't call it Medicaid. Perhaps Medicaid has become stigmatized since it has been a program of the poor. But NAM is very concerned about access and improving that access. We have details in our testimony.

Mr. LEVIN. Mr. Moody wants me to yield. Mrs. Johnson is next. Is it all right? I will yield briefly to Mr. Moody and then call on you.

Mr. MOODY. On that point, before we get off on another point, Medicaid already is a serious cost-shifter, Medicaid, on to the companies that NAM represents. I am startled to hear you suggest we use Medicaid as a vehicle because it is a big cost-shifter to the private sector. It only pays about 60 cents on the dollar.

Ms. CANNER. We are also talking about other cost considerations. We are talking about getting more people into managed care. We are talking about having a better handle on costs. We recommend and talk about State data systems. It really is a whole package. We can't just talk about access per se. We really need to take into consideration the various cost issues involved.

Mr. MOODY. I think the reason Mr. Stark wants to use Medicare rather than Medicaid to solve this problem is that Medicare has purchase power to cost contain far more than 50 separate Medicaid programs, and for many other reasons, it is a much better run program.

Mr. LEVIN. Let me, before calling on Mrs. Johnson, just say I am a bit surprised that there is some considerable support for expanding Medicaid, asking thousands, hundreds of thousands of people who are working to shift into a program that is essentially poverty-based. But maybe Mrs. Johnson will pick that up. We have already encroached on her time. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

I am as surprised, I guess, as my colleague from Michigan is surprised that there is support for expanding Medicaid. I am equally surprised that you all are so optimistic about the impact of expanding Medicare. And I wonder if you are aware that according to ProPAC, this year about half of America's hospitals are going to be losing money on every Medicare patient they admit.

Now, that is important because we have each year struggled to try to keep Medicare reimbursements aligned with costs. We have done a poor job. Think how many urban hospitals there are, with 60, 70 percent Medicare patients. A lot of my rural hospitals are 70, 80 percent Medicare patients. If half of the hospitals are losing money on every Medicare patient, this is a program that is going exactly the same direction that Medicaid has already gone. Medicaid doesn't offer access. It won't solve our problems because we are reimbursing at rates that are so unrealistic and so outmoded that they don't buy care.

When I sat on the Connecticut appropriations committee in the late 1970's, right after malpractice premiums took a big leap and the energy crisis sent everyone's costs up, the committee had documentable evidence from every provider sector that costs were up. Do you know why we didn't increase reimbursements? It was so, so, so simple. Don't forget it. We didn't increase reimbursements because we wouldn't increase taxes. So don't kid yourself. Medicaid is going that direction. We are controlling costs by cutting reimbursements. Sometimes that is justified. Sometimes it is not. If we get desperate enough, it will go faster.

There are really remarkably fruitful other options that through which we can guarantee universal access and a much more powerful approach to cost control than the Federal Government has been able to mobilize. We manage care through HCFA, and when HCFA gets desperate, do you know what my office in my district spends time doing? Trying to convince HCFA that the way to manage reimbursements is to delay reimbursement for 3 months, so you can stay within your budget. The strains out there are enormous in Medicare right now, because Medicare right now, even just with seniors, is increasing $15 billion a year, and we do not have the money.

So, I hope you will not be too sanguine about Medicare as an option. But there is an expanded Federal rule, there are a number of things we must do that we can do. Our community health clinics are providing, in many parts of the country, not all, but in many parts of the country a high-quality care that would address exactly the needs you are talking about, because they have a sliding-scale fee, anyone can use them, and some of them are really classy outfits.

I was just talking to one of my colleagues, frankly, on the other side of the aisle whose town is well-served by these clinics that use a sliding-scale fee, and their emergency rooms only do emergencies, no matter what the income. Their women are getting prenatal care, not under Medicaid, but under a community health clinic program.

If you talked at length with their representatives who were here last week, I will tell you, that is an opportunity for America to provide a level of quality care that, in small towns, for instance, could be used by the most affluent, because it is a sliding scale.

There is a possibility there that it can absorb the unemployed, without you getting into Medicare versus medigap. What are you going to do about the costs of your medigap, as we begin to underfund Medicaid and you are for more Medicare and you are forced to pick it up in medigap costs? Give it 10 years, 15 years, and you will be right back where you are now.

In terms of cost control, HCFA is a micromanager. We rate control. That is what we did in Medicare. That is what we did in the VA system, we bottom-lined dollar control. If you build in managed care, if you reform the malpractice system; there are several powerful things you can put in together. If you require every employer to offer insurance, not necessarily to fund it, but to offer it, you cut marketing costs. If you provide incentives for joint administration, you know yourself, in the union movement, how much you cut administrative costs over a bunch of small businesses.

So, there are six or eight cost control things that, if you put together in an interrelationship, and one is this data issue. There is not a company in my district that has not become competitive, for one reason and one reason only. I have unionized factories, the same union, the same machinery and equipment, but they know what they are doing, they are following their process, the detail of what they are doing, and they are saving costs.

Chairman STARK. If the gentlelady would like to state her question, then we can get finished. If you would finish, we will have a second round.

Mrs. JOHNSON. I will wind right up, Mr. Chairman. My committee colleagues, while you were out of the room, were more stating opinions than questions, and so I have pursued the dialog that has been going on in the committee, and I will be happy to rest up.

Chairman STARK. Certainly, it is the gentlelady's privilege to do that. I was just going to let somebody else have an opinion, and then come back for more.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody?

Mr. MOODY. I would like to question the NAM folks again. You say that Congress should not go after this piecemeal approach. It should focus on the broad issues like the 33 million people without health care coverage. Do you support a big-scale approach, universal coverage, single-payer?

Ms. CANNER. We do not support a single-payer system. We have outlined a number of different things to look at, in terms of trying to get more people covered. As I mentioned, expanding Medicaid, it may not be a Medicaid program that we end up with. Certainly, as some of your colleagues have pointed out, there are some problems with Medicaid, but we really need to look at the other factors, small group market reform——

Mr. MOODY. I have that here and I agree with all of it. Those are all great. No one would quarrel with that, but the question is will they go far enough?

You know, I doubt if they are going to do enough for cost containment to satisfy you or me. It may slow down the growth, but there is such momentum behind the growth. If you do not get market clout purchasing power onto fee structures and global budgets for hospitals and so forth, these are going to be more bandaids, more patchwork.

I agree with everything on your list here on page 2 of your summary, but why do you eschew the idea of market clout to bring fees into line, to get a handle on fees? One of the advantages of Medicare—as you know, is that Medicare costs are rising far slower than private health care costs. Despite the testimony numbers here, the fact is that the per-capita adjusted for inflation rate of compound growth for Medicare is only 3 percent for part A, and 8-plus percent for part B, far lower than the private sector.

One of the reasons Medicare can do that is that it has purchasing power—clout. Why would you not want to apply that to an even larger arena? Why did you give up what is probably the most powerful cost containing tool at your disposal, and opt, instead, for a series of small steps which will have some beneficial effect, but will not get at the real problem?

Ms. CANNER. The point that you are making on market clout, we absolutely agree, and I think it would be important, for instance, to try perhaps an all-payer system as a pilot project in various States, and some of the States are experimenting with a lot of different things at this point.

For instance, I am aware that in Washington State there is a Washington State Health Plan, there is an employers purchasing coalition, and there may be some way of trying to do these things at the State level. I am not throwing it out totally as a bad idea, but all of these increments, things that you mentioned that are increments, have not been tried and I think it is important to at least begin trying these things.

Mr. MOODY. As I say, we do not disagree with these things, but the big weapon for containing costs I think is going to have to be in market power, the way the Canadians do it. Their rate of compound growth, while not great, I think is better than ours. At least, a smaller percentage of their GNP is devoted to health care than ours, as you know.

I see that the NAM supports expanding Medicaid, bringing in all adults and children to Federal poverty level, which would be $10,500 for a family of 3, for example. As you know, this varies tremendously, State by State, at the present time, so there would be a sizable fiscal note on this proposal. Is the NAM prepared to support the taxes required to fund those large outlays that would have to be paid for?

Ms. CANNER. Certainly, we are talking about quite a bit of revenue. What I think is important is that there needs to be an agreement among various members of Congress, in terms of how we are going to do this. I mean, the NAM is not going to tell you at this point we are going to come out and support a massive tax increase, but——

Mr. MOODY. Not a massive tax increase, but would you support the taxes necessary to implement your recommendations?

Ms. CANNER. We would support——

Mr. MOODY. We know Congress will have to make the decision, obviously, but can we count on your organization to support paying for the recommendations that you are putting in your report?

Ms. CANNER. We would like to talk with you about that. I cannot give you the specifics on what it would cost at this point. The NAM would certainly be willing to enter into those types of discussions.

Mr. MOODY. I did not mean a commitment today. I just mean that is obviously going to be the next question, and when you support something, will you help us pay for it or get behind a movement to pay for it.

If I could ask the lady in red, I have heard your testimony about a level playing field. Could you summarize that again? Why would not a global approach take care of that level playing field problem that you describe?

Ms. CONLAN. Right now, the way our members receive health insurance is employers, typically, construction contractors, make dollar-per-hour contributions into the health plan. The construction industry is currently one of those industries that has a very large percent of employers who do not provide insurance for their employees.

Mr. MOODY. At all?

Ms. CONLAN. The exception is, in the unionized industry, because we provided this mechanism which makes it feasible, given the size of the employers and the fact that they go from employer to employer, there is a central pool.

Now, the dollars that the employers contribute—and we estimate that it is approximately $2.50 an hour, which varies by region and by benefit scope, but we estimate that it goes to pay not only for more than our members' benefits. Just like an insurance premium plan, when our members use health care services and the plans pay for those costs, we are paying for the uncompensated care that hospitals are providing for the non-insured construction employees of the non-union contractors.

Mr. MOODY. Just like the NAM.

Ms. CONLAN. Exactly, it is no different. But it seems more galling for us, because we are in a competitive bidding process. We are bidding, typically based on costs. So our employers are not only being responsible in providing this extra compensation for their employees in the way of health insurance, but they are also subsidizing their non-union competitors, we estimate to the tune of about 20 cents per hour worked. That allows the competitors to under-bid them on projects, which will result in possibly more unemployment for our own members.

So, what we are saying is if the non-union contractors were required by some Federal mandate to also provide health insurance, it would reduce the amount of uncompensated care, number one, which would relieve our health and welfare funds, and it would also provide a more level playing field in the bidding arena.

Mr. MOODY. Right. I would argue that the NAM is also in a bidding with the Japanese and other offshore entities that do not put health care in the cost of their goods. They finance it independently of their cost of goods. It is a VAT which is forgiven on exports, so they are in an analogous position with you, actually, it seems to me.

Mr. RINGEN. Actually, they are even in a little more difficult position, because in construction we do not have so much international competition.

Mr. MOODY. Right.

Mr. RINGEN. I do not see how U.S. firms can stay competitive, when health care expenditures are 12 percent of gross national product. That to me is ridiculous.

Let me make one more comment with regard to our plans, Mr. Moody, and that is, as far as I know, the unionized construction sector is the only major sector that has provided coverage during unemployment for about 40 years.

Mr. MOODY. Interesting.

I will finish, as I see the red light is on. You support the mandated coverage approach, as I hear in your testimony, but you would not be averse to a Canadian-style universal all-payer system, either, would you?

Mr. RINGEN. No. If you look at our position, we have said that we are not averse to that at all, we just do not think it is realistic at this time.

Mr. MOODY. Thank you.

Chairman STARK. Before I recognize Mr. McDermott, I just want to give you a little more Milwaukee historical trivia and the great glory of the past of the National Association of Manufacturers. Much of NAM's success is due in great part to Mr. William Grady, who lived in Wauwatosa. As I left Wauwatosa High School on my way to MIT, he gave me a copy, a mimeographed copy of Mr. Welch's original blue book. I did not learn the lessons well at Mr. Grady's knee, but he was indeed an illustrious past-president of the NAM, coming from the great city that Mr. Moody represents, and now of the extreme West Coast.

Mr. McDermott.

Mr. McDermott. I have been a victim of various battles in the State legislature, trying to deal with this thing at the State level, and so I have a lot of feeling for whether it is possible to do it State by State, without some big help from the top.

I really am here to ask a couple of questions of Mr. Huston. What percent of payroll does your company spend on health benefits?

Mr. Huston. I do not have that in my figures, but I will get that answer for you, though. I do not have that exactly.

Mr. McDermott. If you are willing, I would like that figure and also what percent of profit does that represent.

Mr. Huston. All right.

Mr. McDermott. Because under H.R. 1300, Marty Russo's bill, it would cost employers 6 percent of payroll and 4 percent of profit above your current payroll taxes, and I am interested, as I read the NAM proposal, it seems to me, as the Chairman has suggested already, that the tail of liability that hangs out there for so many major manufacturers, in terms of their retirees' health care benefits, should make a national plan that ends those kind of tails of liability very attractive. Additionally, I just cannot see how you control costs, unless you have some all-encompassing system.

I read the NAM proposal and I thought they are trying to put poor people into managed health care or people who do not have a job into managed health care. Now, I am not sure if that is socialized medicine or not, but it looks like you are taking away choice from people on the bottom and saying to everybody else that you have it through your employment, and I still do not see that putting one segment into managed health care will give you enough cost control to make a difference.

As Ways and Means Chairman in the State Senate, I spent year after year with the inflation rate in medical costs being at least twice the national inflation rate. I dealt with that every year by whacking the medical costs right in half, no rationale whatsoever, except to save money, and I am looking for a way to control costs, because everybody, including up here, wants universal access, and what is going to get us is how do we control costs.

I would like to hear how you think the NAM program would really work—because the market has not worked, we have more magnetic resonance imagers in Seattle, we have got 13 of them, which I think is more than all of the western nine provinces of Canada, so I know that the market does not have anything to do with what is going on. So, I would like to hear your explanation of how your plan controls costs.

Mr. Huston. I will develop that for you, sir. I cannot get it to you today, but I will get that to you.

Ms. Canner. I could make a few comments the issue of cost, we struggled very long and hard with it, and, while we have made some recommendations, I do not think it is going to solve the whole problem.

You bring up managed care just for the Medicaid population. More and more employers are reducing choice, if you want to call it that, and putting employees into managed care systems. Perhaps it has been stigmatized, which is unfortunate, but at least the great hope at this point does seem to be managed care, and we really need to give it a good shot.

As to getting to your other points on cost, I will be glad to submit a letter to you. We have had some conversations over on the Senate side with just the same request to us, and I will be glad to furnish you with a letter.

[The information follows:]

NAM

National Association
of Manufacturers

SHARON F. CANNER
Assistant Vice President
Industrial Relations

April 8, 1991

The Honorable Pete Stark
U.S. House of Representatives
Washington, DC 20515

Dear Rep. Stark:

The following pages are in response to questions posed at the Health Subcommittee/Ways and Means Committee hearing on March 21.

Request of NAM on recommendations for cost containment.

- Assure that Medicare and Medicaid and other publicly-supported health programs have adequately funded budgets, pay providers properly and fairly to eliminate cost-shifting to the private sector, and adopt efficient cost management and quality goals that emphasize managed care and use of centers of excellence.

  On the latter point, the Health Care Financing Administration (HCFA) has selectively contracted with four health care institutions for coronary by-pass surgery for Medicare patients. The intent is to identify the hospitals producing the best outcomes, thereby lowering costs over the long term. Details on this quality measurement system for coronary by-pass surgery and subsequent information on other diagnoses should be made available to private payers.

- Permit states greater flexibility in administering Medicaid with an emphasis on managed care. Also, support experiments in prioritization of services, such as that being undertaken in Oregon.

- Encourage the use of managed care in appropriate federal legislation, such as that being proposed for the small group health insurance market.

- Eliminate inappropriate state legislative and regulatory barriers to cost management activities including those laws which limit managed care and utilization review programs; assure that no new state or federal laws be enacted in this area.

- Enact federal reform of the medical malpractice liability system with attention to periodic payments for large awards, offsets for collateral source awards, limiting attorneys' fees, applying a statute of limitations for award of damages relative to minors, and exploring other reforms such as alternatives for resolving disputes over medical claims.

- Fund a research agenda that includes physician and medical initiatives to improve quality of care by developing medical practice guidelines that have been validated through research on patient outcomes, including patient satisfaction; and support the development of uniform information systems to help consumers, providers, purchasers, and concerned others make the best use of the new quality-based system.

- Require demonstration of effectiveness, appropriateness and cost/benefits of technologies for reimbursement under Medicare and Medicaid. (These same criteria now apply to procedures as a condition for reimbursement.) Publicly disseminate this information through the Agency for Health Care Policy and Research (AHCPR) so private payors can benefit from these developments. This reform is one of many needed to improve the efficiency and fiscal soundness of this program.

- Enact legislation requiring all states to develop a uniform minimum data set for the collection of hospital and physician treatment outcome data and related cost. Publicly disseminate analysis of the data as a means for improving health care decisions by purchasers, providers and patients. (Act 89 passed by state of Pennsylvania is an example of this approach.)

- Eliminate existing state laws which require coverage of specific medical procedures/treatments and/or classes of providers. Reform coordination of benefit rules to assure that dual coverage does not result in reimbursement over 100 percent of expenses.

- Encourage health care consumerism through point of service cost-sharing to motivate consumers to take responsibility for decision-making in their own health care.

- Fund undergraduate and graduate medical training through explicit nonpatient care means. Promote research and training in cost-effective primary health care delivery, public health and resource needs. Require medical schools to include a rotation in family medicine just as they currently require rotations in internal medicine, pediatrics, etc.

- Discourage physician self-referrals to their own laboratories, x-ray facilities and other entities in which they have a financial interest.

- To summarize NAM's recommendations, the central focus is on cost control, improving the quality of care, encouraging health care consumerism through cost-sharing and active participation in one's own health, encouraging the federal government to be a more cost-effective purchaser and not shift costs to the private sector, reducing defensive medicine costs, reducing regulatory barriers to cost containment and otherwise making the marketplace work more efficiently. This approach is preferable to strict regulatory controls which are likely to invite provider "gaming" of the system and other abuses.

The NAM appreciated this opportunity to respond to the Subcommittee's questions and participate in the hearing on health insurance and the unemployed. Attached is the corrected transcript.

Sincerely,

Sharon F Canner

Sharon F. Canner

Mr. McDermott. Unless you are talking about dealing with 99.7 percent of the 37 million unemployed, I think you will always have leakage that will begin to be spread around onto other people. You cannot do it for only 60 percent of the uncovered, I believe, or 71 percent. If you leave any major segment out there, you are going to find that you are going to get some cost shifting, and the thing begins to unravel again.

That is why I personally, in coming to the point, I used to think you could do it province by province or piecemeal, but I now think the only way to do it is with some kind of universal program that puts its arms around all of the costs and says this is what we are going to pay for an appendectomy, whether it is done in Seattle, Chicago or Memphis, Tennessee, and you are going to have to begin making some very tough decisions to get the program in place. I do not see any other way.

In the time left, I would like to hear about the Canadian system and what you do up there that you buy as an additional system. You mentioned it in the Chairman's remarks, and I would like to hear a little expansion on that.

Mr. Ringen. Let me first comment on the issue that you raised with them. In our plans today we provide, the cost of health care is roughly 13 percent of the total wage and benefit package, and that is up from about 8 percent in 1980, and we rolled back benefits in the same period.

Mr. McDermott. So, 6 percent would not be—the construction companies would not mind if it was only 6 percent of payroll.

Mr. Ringen. No, that would be terrific.

Mr. McDermott. Okay. Go ahead.

Mr. Ringen. We are doing a number of things, in terms of cost control, including in the Northwest, where we are trying to coordinate plans and put together a lot of market forces, but that is not going to do the job. You are simply not going to control capital expenditures for MRI's through some sort of market mechanism.

If you look at Canada, let us say British Columbia. Where hospital costs are paid through general revenues through block grants to each hospital, essentially, and part of that funding comes from the Federal Government's Medicare program, so it is a joint Federal-provincial system and financing is different in each province.

Our plans are supplemental to that.

In British Columbia, we provide annual physical examinations, we provide regular hearing tests, which is something that is very important for construction workers. We do lung examinations, we provide dental services, prescription drugs, extra life insurance benefits, and so on, and those are the kinds of things that go beyond the basic medical program that the government would provide. It does not provide for prescription drugs, it does not provide for general preventive medical services, it does not provide for dental services, and so on, and we cover those, and that is negotiated between the union and the employers.

It is great for the union, because these are benefits that the members really see very tangibly every year and, at the same time, we do not have the high-cost items, which is the hospital care.

In terms of what you say with regard to the State by State system, I think the Canadians are finding that they have to do more in terms of providing are greater uniformity between the differential provincial systems, and that each of them is now struggling with cost control problems, even though they do a much better job than we do of capital expenditure control, as well as reimbursement.

For instance, a surgeon who will do open heart surgery in Vancouver will get paid about $1,600, and an American surgeon in Seattle doing that procedure can expect $6,400. That is the difference. Physicians' salaries are not outrageously out of line in Canada, like they are in the United States.

We believe that trying to do it State by State, taking a State-by-State approach, as has been discussed here, is totally unreasonable. If you want to look at one State-by-State program that does not work at all, take a look at workers' compensation and what that does to people.

There has to be Federal regulatory efforts.

I also think, in response to something that Mr. Moody said, that you are not going to have market mechanisms control these costs by themselves, you have to have a regulatory approach with regard to the rate-setting for both inpatient and outpatient services, and you have to have strong capital expenditure controls, and that the Federal Government has to do.

Mr. McDermott. Thank you.

Thank you, Mr. Chairman.

Chairman Stark. I have never felt that we could install the Canadian system, but I certainly would like to dissuade the public from listening to what I think is a very serious misinformation campaign by the AMA to try and convince people that it is a disaster, because I think that is not at all true. It may not work here, but arguably it does work there.

Mr. Ringen. I would like to make one comment about that, if I may.

Chairman Stark. All right.

Mr. Ringen. At our meeting in Florida in February, we had delegates from all over the United States and Canada, we had about 400 delegates there to discuss health care issues. We asked the delegates, "are you happy with your health care system?" We asked it first of the Canadians, and every one of them was generally happy with their health care system. We asked the American delegates the same question about the American health care system, and with the exception of one or two, every one of them was unhappy with the system.

Chairman Stark. I wanted to take this opportunity to lobby Mr. Huston a little bit. I am not unfamiliar with the problems that you face in the manufacturing business, although my successes in it nowhere equal those of yours and your company's.

Often, I think instinctively, people who are in business and understand questions of cost and cost savings tend to think that we can apply these strategies to medical care, and I want to just suggest to you that it is so different.

For example, you and I do not buy medical care. It has often been suggested that if we just up the copay a little bit, people would not over-utilize. Neither of us, if it was a nice afternoon and we both got the afternoon off, we would go shopping downtown for a proctoscopic examination, no matter how inexpensively I could find out. And if you get the weekend off, I do not want to go to the hospital for a week. [Laughter.]

We instinctively, as a public, do not like hospitals. We like doctors socially, but we do not like to go to them. So, we are the wrong people to work in a market.

You probably have somebody in your company who is an expert, but then, by the same token, where your principal factory is, you may be a big purchaser. Thus, through a variety of ways you may be able to negotiate with a hospital and a group of doctors to hold your costs down. But your sales office in Oakland, California, which is only staffed by eight people may be out of luck. Therefore, your costs there are going to be shifted to you, because you do not have the purchasing power there, and we get into this box.

I will take all-payer, if I cannot get single-payer, but at some point we have to deal with just egregious waste of capital resources, because hospitals instinctively want to provide services for the doctors. In New York State, we have 99 percent occupancy. But in my home State of California, we have only a 50 percent occupancy rate. We have MRI's where we do not need them and no MRI's where we do need them. It costs you and me. We have got to find a way to resolve this.

The real pitch I want to make is, I almost solved for you and your members your unfunded liability. The catastrophic bill that Mr. Gradison and I wrote saved hundreds of billions of dollars for major manufacturers in this country, because we took off the responsibility for over $2,500 of your unfunded retirees' liability.

Now, had we got you to help us, we might not have lost it and had it repealed. We did a bad selling job to the public and now the seniors are going to have to pay for it. If you think back, the unfunded liability is about $400 billion, $2, $3 or $4 billion, I am not exactly sure I know what it is, but it is a big number. We might have cut that by three-quarters.

So, there is a way that I see that we are going to have to come together, the Fortune 500 companies. Our biggest problem actually is going to come from your brothers and sisters in free enterprise and the U.S. Chamber, the NFIB. We are going to have to talk about 50 cents an hour or $1 an hour minimum benefit increases, and that is like a minimum wage increase.

But we may have to bury that one and say we are going to have to get together and roll the U.S. Chamber, because the small business guys are going to have to pick up their share in some way. Now, admittedly, we cannot have them go broke. We will have to deal with that.

I want to thank you for joining with us. I want to urge you to work with us. I think the chief financial officers are coming close to saying we ought to have some kind of national payment plan. But I am not sure the CEO's are going to buy it. But let's work together and see what we can do.

We have to get something done, and I think you all are going to see it in a very empirical sense. All I can say is you are going to find this committee is receptive. I think in another year or two, you are going to find an administration that is going to have to deal with a domestic policy certainly in the health issue. For whatever reason it is not on the table this year, that does not mean we can ignore it very long.

So, this is a genuine invitation to work with us. I think we can do it efficiently and it will be something we can be proud of. It will also help you and other people in the business community.

I want to thank all of the witnesses. Some of them are closer to where I am coming from right now. I am going to have to admonish the members of organized labor. We are going to have a tough problem dealing with some of the workers who now do not pay a nickel, as they see it, out of their paycheck for health care.

If the plan comes back and says, "Hey, guys, it is going to cost you all $400 or $500 a year," then they are going to look at me and say, "What the hell, I thought you were a friend of labor, I got it free then." The fact is that they are only going to have it free until somebody comes in and buys the company and shoves off the retirement plan under Executive Life of Los Angeles, and then they are going to be out of gas.

We all have a tough selling job and we all have a problem putting it together, but I thank all of the witnesses for your willingness to work with us here, and I appreciate your testimony this morning.

We have a third panel, comprised of the Honorable David Ramsey, the secretary of the Louisiana Department of Health and Hospitals, who is representing the National Association of Public Hospitals; Mr. John Bartkowski, the executive director of the 16th Street Communitv Health Center, in Milwaukee, Wisconsin; and Dr. Gail Anderson, the associate medical director of the Grady Memorial Hospital, Atlanta, Georgia, representing the American College of Emergency Physicians.

Where is the 16th Street Community Health Center?

Mr. BARTKOWSKI. 16th and Washington.

Chairman STARK. Washington Boulevard?

Mr. BARTKOWSKI. Washington Street.

Chairman STARK. Where is Washington Street?

Mr. BARTKOWSKI. Two blocks south of National Avenue.

Chairman STARK. You have a marvelous accent. Across the viaduct, as we used to say. They did not allow German kids that far south in my day. [Laughter.]

Secretary Ramsey, would you like to proceed?

STATEMENT OF DAVID RAMSEY, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS, BATON ROUGE, LA, AND MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. RAMSEY. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am very pleased to have this opportunity to testify this morning on behalf of the department, as well as in my capacity as a member of the board of directors of the National Association of Public Hospitals.

NAPH has, for the last decade, represented a significant portion of America's metropolitan area safety net hospitals. Today, NAPH members include 100 hospitals, many of which are located in urban areas that have experienced significant increases in unemployment and, thus, a number of uninsured patients, as well.

As you may know, the State of Louisiana owns and operates the public safety net hospitals in the State, in the form of 10 hospital charity systems known as the Charity Hospitals. We feel that we are well placed to comment on the impact of the recession on safety net hospitals, Mr. Chairman, because Louisiana has been in a recession for a longer period of time than the rest of the Nation.

Louisiana's Charity Hospitals run on an admission criteria different from most hospitals in the country. Priority is given to those who are uninsured, with those able to pay admitted on a space available basis. Because the need is great in Louisiana, and because the recession has had a significant impact on our ability to finance this system adequately, access has had to be limited, at times.

Unemployment in Louisiana during the 1970's fluctuated around the national average. In the 1980's, however, it rose significantly above the figure, at times, to nearly double the national rate.

In 1988, a GAO study estimated that 22.8 percent of Louisiana's population under age 65 were uninsured, and we know that number is even higher today. In addition to those in poverty, nearly half a million of the near-poor, including many with low-wage jobs, are also uninsured in Louisiana. It can be conservatively estimated that we have about 926,000 uninsured in the State——

Chairman STARK. How many?

Mr. RAMSEY. 926,000, about 23 percent of the population.

Chairman STARK. And you take care of them in 10 hospitals?

Mr. RAMSEY. Yes, sir, and an undetermined number of under-insured people in the State.

In many respects, our approach to health care in Louisiana can be considered an institutional form of national health insurance. Health care is provided through the Charity System to all individuals who need it, without regard to the ability to pay.

Our 10 hospitals, representing a small percentage of the 160-odd hospitals in Louisiana, deliver a third of the babies, nearly half of the outpatient visits, and accommodate one-third of all emergency room visits in the State.

It should be noted that increased demand on the hospitals, combined with a decline in accessibility, has resulted in significant increases in waiting times for admissions, clinic and outpatient visits, and elective surgeries. If one can get into our system, the care is excellent, but often people cannot get in.

Chairman STARK. Do the doctors participate? In my county, we have a county hospital which gets the uncompensated care and the poor, and basically the doctors will avoid it like a plague. The specialists will not show up, I cannot get coverage in the emergency room partly because of the Medicaid in California. They are not paid and at some reasonable point, I do not blame them.

What happens in Louisiana? Do the prestigious doctors serve in your 10 hospitals?

Mr. RAMSEY. No, sir, our hospitals are staffed really by university faculty. Our hospitals serve, as well, as the university hospitals for the State.

Chairman STARK. So, the teaching doctors are there?

Mr. **Ramsey**. Yes, sir. We have what amounts to a combined county hospital-university hospital. We do not have county hospitals and we do not have university hospitals, they are all in one.

Chairman **Stark**. So, if they want to get in and get rich, they have got to serve their time?

Mr. **Ramsey**. Absolutely. Most all of the physicians in the State have come through the system for their training.

Chairman **Stark**. That is great.

Mr. **Ramsey**. I know that all of this sounds bleak, and it is, but we are addressing the issues facing our public hospitals. Louisiana's economy has been improving, although many remain in poverty, with low-wage jobs, as well.

The economic recovery in Louisiana may be slowed by the new national recession, but it has come back from an extremely low point. Business at this time is likely to regard the recovery as fragile, and it is not probable that any significant expansion of insurance coverage will be offered in the near future.

But on its own, our efforts to improve our safety net hospitals will not assure access to care for Louisiana's 926,000 uninsured. Only a restructuring of our country's health care system can accomplish that.

We also believe that it is important for the Congress to consider several interim reforms to protect further viability of safety net hospitals. Direct institutional support for safety net hospitals serving large numbers of uninsured, low-income patients in the form of a national uncompensated care trust fund and dedicated source of revenues—legislation originally developed by you, Mr. Chairman, could serve as a model—a new national capital financing initiative, as well, and, finally, there should be continued support for the Medicare disproportionate share program.

Thank you, sir.

[The prepared statement follows:]

Statement of The Honorable David Ramsey
Secretary
Department of Health & Hospitals
State of Louisiana

before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives

March 22, 1991

Mr. Chairman, members of the Subcommittee, I am David Ramsey, Secretary of the Department of Health & Hospitals of the State of Louisiana. I am very pleased to have this opportunity to testify this morning on behalf of the Department, as well as in my capacity as a member of the Board of Directors of the National Association of Public Hospitals (NAPH), on the impact of the recession and increased unemployment on our nation's public safety net hospitals. We commend you, Mr. Chairman, in your efforts to highlight the issues surrounding access to needed health care for unemployed workers and their families.

NAPH has for the last decade represented a significant proportion of America's metropolitan area safety net hospitals. Today, NAPH members include 100 hospitals, many of which are located in urban areas that have experienced significant increases in unemployment (and thus in the numbers of uninsured patients in need of health services) in recent years.

As you may know, the State of Louisiana owns and operates the public safety net hospitals in Louisiana, in the form of the ten hospital Charity system known as the Charity Hospitals. We feel that we are well placed to comment on the impact of the recession on safety net hospitals, Mr. Chairman, because Louisiana (like other states in the oil patch) has been in a recession for a longer period of time than the rest of the country.

I would like to accomplish three things in my prepared testimony this morning: First, I would like to describe the current situation of the Charity Hospital system, including the demands on that system of the unemployed and uninsured and the impact of the state's general fiscal problems on the ability to fund operations and capital. Second, I would like to offer you some general observations on utilization demands and financial trends among public hospitals generally. And third, I would like to offer several proposals for federal reform and comments on the President's Medicare budget proposals, which are before this committee.

IMPACT ON THE CHARITY HOSPITAL SYSTEM

Louisiana's Charity hospitals are run on an admission criterion different from most hospitals in this country. Priority is given to those who are uninsured, with those able to pay admitted on a space available basis. Because the need is great in Louisiana, and because the recession has had a significant impact on our ability to finance this system adequately, access has had to be limited at times.

> Last year, due to a lack of nursing staff at Charity Hospital in New Orleans, we had to close 150 of the 650 operational beds. In order to prevent an overload on the private sector hospitals, and to provide access to the uninsured, we transferred insured patients to the private hospitals or guaranteed payment of those who were not insured.
>
> In Baton Rouge, at Earl K. Long Memorial Hospital, we transferred insured critical care patients to the private hospitals in order to provide a bed in the ICU for patients waiting in the Emergency Room, and thus avoid closing the ER by diverting ambulances.

Unemployment in Louisiana during the 1970s fluctuated around the national average. In the 1980s, however, it rose significantly above the national figure, at times to nearly ***double*** that rate. As of January 1990, Louisiana's unemployment had fallen to the point that it equalled the national average, at 7 percent. While encouraging, Louisianians are well aware that this has been achieved in part by population loss. We were one of the few states to have lost population from 1980-90, by an amount sufficient to reduce the size of our congressional delegation from 8 to 7.

Estimates have been given nationally that between 15 to 18 percent of the population is without health insurance. A 1988 U.S. GAO study estimated that 22.8 percent of Louisiana's population under age 65 were uninsured - and we know that the number today is even higher. In 1987, there were an estimated 908,000 individuals in Louisiana below the poverty line. Of these only 516,000 were eligible for Medicaid. In addition to those in poverty, nearly a half million of the near-poor, including many with low-wage jobs, are also uninsured in Louisiana. ***It can be conservatively estimated that we have about 926,000 uninsured in the state, and an undetermined number of others who are uninsured.***

In many respects our approach to health care in Louisiana can be considered an institutional (as opposed to an entitlement) form of "national health insurance". Health care is provided through the Charity System to all individuals who need it, without regard to ability to pay. ***In fact, about 60 percent of our patients are uninsured.***

The System does not provide just inpatient care - we are the family doctor to the state. We deliver a much higher volume of clinic, outpatient and related services than do community hospitals. Our ten hospitals, representing a small percentage of the 160-odd hospitals in Louisiana, deliver one-third of the babies, account for nearly half of all outpatient visits, and accommodate one-third of all Emergency Room visits in the state.

The Charity hospitals also serve as the university hospitals for the state. In addition to providing clinical training to virtually all of the state physicians, it also trains a significant number of nurses, technicians and other patient care professionals.

The Subcommittee must be aware that the State of Louisiana has been severely impacted by the recession, and, therefore, funding for our hospitals from the State is not increasing in terms of "real" dollars. When controlled for the rate of hospital cost inflation, in "real" dollar terms there has been a 25 percent decline in total operation budget of the System in the past five years. This represented a loss of nearly $120 million in spending power. Today, the total System budget is just slightly over $400 million.

In addition, spending on renewal of plant and medical equipment has been far below the industry standard. For example, in 1988 our hospitals spent only

$2,919 per bed on plant and equipment. This amount was ***only 12 percent as much as spent by a comparison group of 48 Louisiana community hospitals.***

It should be noted that increased demand on the hospitals, combined with a decline in accessibility, has resulted in significant increases in waiting times for admissions, clinic and outpatient visits, and elective surgeries. We have had to close beds - over 250 in 1987, representing nearly 10 percent of the beds in the System - and have lost resident physicians in significant numbers in the hospitals outside New Orleans. From 1985 to 1990, we declined from 953 to 700 filled residencies in our hospitals, a loss of 154 physicians to our patients. ***If one can get into our System, the care is excellent. Often people cannot get in.***

I know that this all sounds very bleak, and it is. But, we are addressing the issues facing our public hospitals. Louisiana's economy ***has*** been improving, although many remain in poverty and low-wage jobs are still widespread. There are still many people with no insurance. In fact business in Louisiana, especially ***small*** business has grown accustomed to depending on the hospital System. It softens the impact on their employees if they do not provide health benefits.

The economic recovery in Louisiana may be slowed by the new national recession, but it has come back from an exceedingly low point. Business at this time is likely to regard the recovery as fragile, and it is not probable that any significant extension of insurance coverage will be offered in the near future.

This year the Louisiana legislature will decide whether the Charity Hospital System becomes a model for the rest of the country or goes back to business as usual. Legislators will be asked to transfer the hospital System to the ***Louisiana Health Care Authority***, and to restructure its governance and create the basis for a dramatic shift in the financial strategy for capital improvements in the hospitals.

But, on its own, this new structure will not assure access to care for Louisiana's 926,000 uninsured. Only a restructuring of our country's health care system can accomplish that.

IMPACT ON PUBLIC HOSPITALS

NAPH recently released a major study of urban safety net hospitals, a White Paper entitled "America's Health Safety Net". Drawing on NAPH's newly released White Paper, it is possible to illustrate several important aspects of the current situation of such hospitals, including changes that have occurred in recent years as a result of increased demands by uninsured and unemployed patients:

- Bad debt and charity care as a percent of charges increased from 22% in 1982 to 42% in 1988.

- NAPH hospitals had an average net operating deficit of more than $9 million, even after direct local subsidies were taken into account; this represents an increase from $6.6 million in 1986.

- Occupancy rates in NAPH hospitals are high, rising from 77% in 1985 to 81% in 1988.

- Demand for outpatient services in NAPH hospitals is increasing. It has gone from an average of 180,000 visits per hospital in 1986 to an average of more than 212,000 visits in 1989.

- 30% of the inpatient days and 52% of outpatient visits in NAPH hospitals in 1988 were for patients with no source of payment.

- **53% of all admissions to NAPH safety net hospitals were through the emergency department in 1988 (more than 70% for some hospitals), and many emergency and clinic patients are waiting longer to see doctors or be admitted.**

- NAPH members today treat an increasing number of patients from special populations, including persons with AIDS, drug abusers, trauma victims, the deinstitutionalized mentally ill, the homeless, and other low income patients in need of long term or home care.

Summary of Recommendations for Reform

The information and analysis presented in this testimony illustrate with precision the immense problems faced by America's safety net hospitals. For this reason, NAPH has several observations on the President's budget, appropriate criteria for a national health plan, and the need for other immediate reforms.

With respect to the President's Medicare budget, it is important to note that Medicare is usually the single most important ***non-indigent*** payor in many safety net hospitals, and as such, constitutes an essential part of patient care revenues. For this reason, NAPH strongly opposes the Administration's Medicare budget proposal, which would reduce Medicare spending by $2.8 billion more in FY 1992 than was agreed to in OBRA 1991. A significant proportion of that reduction would come from the indirect teaching adjustment, which would be decreased from 7.7% to 4.4% in FY 1992, and to 3.2% by FY 1996. NAPH also opposes the proposed reduction in direct medical education payments by $140 million and the proposal to "save" $670 million by delaying the hospital update for three months at the beginning of the next fiscal year.

Finally, with respect to Medicare GME payments, 1991 saw a significant effort to recoup past direct medical education payments ***by changing reimbursement rules and then attempting to apply those changes retroactively.*** HCFA's major efforts last year to audit GME payments on the basis of regulations adopted in 1989 are based on Federal legislation adopted by the Congress in 1985. However, we are concerned that the HCFA regulations and audits differ in several major ways from the original statutory intent, and further, with the retroactive application of 1989 regulations to cost reports dating all the way back to 1984. We are pleased and grateful that the Congress, with the leadership of your Committee, intervened in OBRA 1990 to slow down HCFA's recoupment effort. We are concerned that considerable additional vigilance in this area will be called for on your part this year, and we hope to work with you closely on this important matter.

With respect to universal health coverage, NAPH believes that this must remain the single most important legislative and policy goal of our nation's health system. For that reason, and as this Subcommittee requested last year, NAPH has adopted the following criteria for a national health plan:

- While incremental improvements are acceptable in their own right, the goal of any national health plan must be nothing less than universal access or coverage for all.

- However, not every individual needs to receive ***insurance*** coverage to be guaranteed true access under a universal health plan; it must be recognized that there will always be individuals who fall through the cracks, and that it is acceptable to provide access for such persons through the preservation of a strong and well-financed ***institutional safety net.***

- A national health plan must require the federalization of the Medicaid program, and quite possibly its elimination and merger with Medicare.

- A core national minimum benefit package must be developed that is not too rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the prospects of catastrophic illness.

- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).

- States must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.

- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.

Finally, we also believe that it is important for the Congress to consider several interim reforms to protect the future viability of safety net hospitals.

Direct institutional support for safety net hospitals serving large numbers of uninsured low income patients, in the form of a national uncompensated care trust fund, with dedicated sources of revenue. Legislation originally developed by you, Mr. Chairman, and introduced in the last Congress as H.R. 754, could serve as a model.

A new national capital financing initiative is also needed to rebuild and equip our health safety net infrastructure. A new NAPH study, which I have submitted to your staff, estimates that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. Options for such an initiative might include direct federal grants and loans, debt service subsidies, and credit enhancements such as mortgage or bond insurance. While we do not envision such a program directly involving Medicare capital payments, it may be possible to draw upon the financial strength of the Medicare trust fund to enhance the credit of safety net hospitals. Eligibility for such a new program should clearly involve a high standard of need in urban and rural areas, and hospitals accepting assistance should probably also be willing to meet long-term indigent care and community service requirements, and perhaps other reporting and utilization requirements.

We look forward to working with this Subcommittee to develop some appropriate options in each of these areas. I would be happy to answer any questions you may have at this time.

Chairman **Stark**. Do you think Earl Long dreamed that all up, or did it just kind of happen that way. Was it part of his ground plan to get the teaching hospitals or was he just lucky?

Mr. **Ramsey**. Well, I think it started out not as a grand scheme, and it eventually got lucky. Frankly, 5 years ago, before the reforms in health care came about that we have today, people would look at our system and say it was archaic. But given how things have transitioned, we are now really in the forefront and the potential of a national model.

Chairman **Stark**. Thank you very much.

How are things in Milwaukee, Mr. Bartkowski.

STATEMENT OF JOHN BARTKOWSKI, EXECUTIVE DIRECTOR, SIXTEENTH STREET COMMUNITY HEALTH CENTER, MILWAUKEE, WI; ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Mr. **Bartkowski**. Good morning, Mr. Chairman and members of the committee.

My name is John Bartkowski and I am the executive director of the Hope, Inc., which is more commonly known in Milwaukee as the 16th Street Community Health Center.

I would like to just start by thanking you, Mr. Chairman, and thanking Congressman Moody, for your strong support of cost-based reimbursement for community health centers. It will have a significant impact on our ability to operate, and soon as the State decides to implement it, I think we will be doing much better.

Community health centers, for over 25 years, have seen on a daily basis the consequences and the costs of delayed access to care. The unemployed and low-income patients that we see at 16th Street in Milwaukee routinely delay coming in for care. Many are unemployed, and of even those lucky enough to be employed, few have health insurance. So, delaying health care until absolutely necessary becomes routine in such families, simply in order to save limited resources.

Last year, 16th Street Community Health Center provided over 50,000 patient visits to Milwaukee's low-income community; 92 percent of our clients are below the poverty level, and 32 percent are completely uninsured. Nevertheless, communities that are served by community health centers are the lucky ones.

We are constantly reminded of the large number of persons we cannot serve. At 16th Street, we are currently turning away over 150 people a month, because we simply do not have the physical capacity or the financial resources to see any more patients. This is a significant increase from just 6 months ago, and in talking with these patients, we found out that many of them are recently unemployed or have been unemployed in the last 6 months.

The millions of needy Americans who do not have access to health care typically must undertake a lengthy and frustrating search for providers willing to see them for free, which is a rarity, or willing to accept Medicaid, which is becoming a rarity, or they must go to emergency rooms for routine care, despite waits of up to 12 hours or more, at even greater cost to our health care system.

Unfortunately, our experience has been that, in most instances, people simply go without care. Recent national studies document that a great number of health services are typically not available for those who lack insurance.

Prenatal care, with its lack of urgent, obvious, painful conditions, is often one of the services unemployed women often do not get. Unfortunately, the result of this is often sorrowful stories of low birth-weight babies, developmental disabilities, or early infant death.

I would just like to share with you some recent examples from our own experiences in Milwaukee of the debilitating health effects of lack of coverage among the unemployed, particularly as it relates to pregnant women.

The first case is that of an Hispanic woman, 6 months pregnant, who delayed prenatal care for 4 months after learning that she was pregnant, which was already late in her first trimester, because her husband was unemployed. This family has no source of income. Other family members are helping them with rent and food.

The woman, now receiving care at our clinic, has no way to pay the clinic or the hospital for the care that she is receiving and has received. Her worries about money are only compounding her worry about having delayed care for her baby. Our only hope is that she will not stop coming to us for prenatal care, because of her worries about the cost of that care.

I might add that if the President's proposal to shift funds from community health centers to fund infant mortality projects across the country takes effect, this woman may not be able to come to our center any more, because we may not have the capacity to see her.

In another case, a woman very near delivery was referred to our clinic by the City Health Department. She had received no prenatal care, because she had no insurance coverage. Her husband made only $200 a week, working for a company that did not provide health insurance coverage. She, nevertheless, took all four of her children to a hospital family practice clinic for immunizations and check-ups, and was presented with a bill of over $500.

She has since been hesitant to seek any care for her children, although they have had a variety of illnesses. Her husband was recently injured on the job and is unemployed. He has to date received no income or compensation since the injury. This woman has not returned to our clinic for care following her delivery and, unfortunately, because we have had to reduce our outreach efforts, we currently do not know what the status of that baby is.

Another case is that of a family with two children, who had no income for over a year. The entire family has gone without medical care for most of that time, because of limited savings and in hopes that the husband will be called back to his job, a job that did offer health insurance.

His wife, however, has developed an increasingly painful orthopaedic condition which requires the earliest attention. Unfortunately, again, we do not have the financial resources to provide anything but primary care services for the family.

The last case is that of a 21-year-old Hispanic man who is unemployed and has been without health insurance for almost a year.

He has been taking part-time temporary employment, when available. He and his wife and their two children care for his 12-year-old brother, because both of their parents are deceased.

After the 12-year-old began experiencing hearing and vision problems, his brother used their remaining savings to take him to a physician. Upon examination, the boy was referred to a specialist and diagnosed with a brain tumor. Because of the lack of insurance, he was referred to us for the care he needed. Again, we do not possess the resources to pay for the services he requires, such as radiation and chemotherapy treatment.

To make matters worse, because the brother cannot afford to provide for this child's health care needs, the county has taken custody of the child and wants to remove the child from his brother's home.

These are just a few of the cases that we see on a daily basis. Milwaukee's unemployment rate was 5.2 percent in January of 1991, representing about 17,000 families. Now, this rate may seem to be good, when you compare it to the national average. However, a recent New York Times article, in fact this last Tuesday, pointed out that Milwaukee's unemployment rate in the minority community is over 20 percent, making it one of the worst unemployment rates in the country.

The few cases I have presented today demonstrate the dilemma unemployed families find themselves in, when health care services are necessary. The longer they remain unemployed, the more severe and complicated their conditions become, and the more costly the services are to treat.

I know that this committee understands that if it were not for community health centers like ours, most patients would not even be able to secure basic primary care services. However, those of us on the front lines of the access crisis every day also are acutely aware that the 600 federally funded community health centers are able to serve only 1 out of 5 people who need them.

We are constantly frustrated with our inability to serve all of the people who require not only primary, but specialty and inpatient care. We, the community health centers, like most of our patients, are struggling to do what we can, often in the face of insurmountable odds. Believe me, they and we need all of the help that you can offer. I believe this bill that we are discussing today can provide some of that help.

Again, Mr. Chairman, thank you for giving me the opportunity, and I would be more than happy to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT OF JOHN BARTKOWSKI, EXECUTIVE DIRECTOR, SIXTEENTH STREET HEALTH CENTER, MILWAUKEE, WI, ON BEHALF OF NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Thank you, Mr. Chairman. My name is John Bartkowski and I am Executive Director of the Sixteenth Street Health Center in Milwaukee, Wisconsin. Community Health Centers daily see examples of the cost of delayed care. The unemployed and low-income patients we see at 16th Street in Milwaukee routinely delay in coming in for care. Many are unemployed; even for the employed, few have health insurance, so delaying health care until absolutely necessary becomes routine in such families simply in order to save money.

The 16th Street Community Health Center provided over 50,000 patient visits last year to Milwaukee's low income community. Ninety-two percent of our clients are below the poverty level and 32 percent are completely uninsured. Nevertheless, the communities served by health centers are the lucky ones -- we are constantly reminded of the large number of persons we cannot serve. The millions of needy Americans who don't have access to a health center typically must undertake lengthy and frustrating searches for providers willing to see them for free or to bill Medicaid, or they must go to emergency rooms for routine care despite waits of 12 hours or more, or, most commonly, they go without care.

Recent national studies document the great number of hospital procedures typically not available to those who lack insurance. Prenatal care, with its lack of urgent, obvious, painful condition, is greatly affected by this combination of impaired access and impaired care. Unfortunately, the result is too often sorrowful stories of low birth weight, developmental problems, or even early infant death.

Permit me to share with you some examples, from our experience in Milwaukee, of the debilitating health effects of a lack of coverage among the unemployed, particularly in pregnancy.

> A hispanic woman, six months pregnant, had delayed prenatal care for four months after she learned she was pregnant, because her husband was unemployed. They have no source of income. Family members are helping with rent and food. The woman, now receiving care, has no way to pay the clinic and hospital bills she is incurring, which are already over $500. Her worries about money are only compounding her worry about having delayed care for her baby.

> A family with three children moved to Milwaukee recently. The father found part-time employment, but without health insurance. The mother, several months pregnant, delayed prenatal care for herself and primary health care for her three children -- including vaccinations. The family was then accepted into the WisconCare program, a state-funded effort which was initiated by Wisconsin's health centers with federal Jobs Bill funding received during the last recession in 1982, and which provides discounted care to unemployed families. The father began working full time at $200 a week; however, he was recently laid off. Since that time his wife had to be taken to the emergency room, but the state program does not cover that service, and thus the cost has been added to her other health bills.

> A woman very near delivery was referred to our clinic by the city health department. She had received no prenatal care because she had no insurance coverage. Her husband made $200.00 per week. She nevertheless took all four of her children to a hospital family practice clinic for immunizations and check-ups, and

was presented with a bill for $524. She has since been hesitant to seek medical care for her children, although they have had a variety of illnesses. Her husband was recently injured on the job and is unemployed; he has not received any compensation since the injury. Since she has not returned to the clinic for care following her delivery, and we no longer have community outreach workers due to a terrible shortage of funds, we do not know how her new baby is doing.

> A 38 year old hispanic woman and her eight year old daughter are being supported by her sister; she has no income of her own. She is being treated for painful carpal tunnel syndrome. Because she has no insurance, and we cannot afford to pay for specialty referrals, a possible surgical referral is not an option.

> A hispanic family, a couple with two children, has brought in no income for over a year. The entire family has gone without medical care for most of that time, in the hope that the husband will be called back to the job he held before, where he had family health coverage. His wife however has developed an increasingly painful orthopedic condition in her back requiring the earliest attention. Here too,we simply do not have the resources to help.

> A 40 year old man, unemployed for six months, has been unable to find affordable health care for himself, his 40 year old wife and four children. They have received no health care in that half-year. He has told us he is willing to take **any** job at **any** pay in order to receive health insurance coverage.

> A 21 year old hispanic male, unemployed for almost a year, is taking part-time, temporary employment when available. He cares for his 12 year old brother, who is experiencing vision and hearing difficulties. He went to a physician, despite being unable to pay. Upon examination, the boy was referred to a specialist and diagnosed with a brain tumor.

Milwaukee's unemployment rate was 5.2 percent as of January 1991, representing about 17,000 families. The rate has been rising rapidly over the last six months. A New York Times article on Tuesday of this week pointed out that Milwaukee's unemployment rate was over 20 percent for blacks.

The few cases I have presented today demonstrate the dilemma unemployed families find themselves in when health care treatment is necessary. The longer they remain unemployed the more severe and complicated their conditions become - and the more costly and difficult the care they require. The financial burden that the unemployed experience from incurring medical bills they cannot pay adds greatly to their distress, so many without jobs understandably but dangerously put off health care until absolutely necessary. Even with community health centers, such as ours in Milwaukee, where clients pay according to an income-based sliding fee scale, clients can run up bills of several thousand dollars. When our patients require medical referrals to specialists, the cost to the client is absolutely prohibitive, and many clients simply don't go.

We clearly understand that, were it not for our health center, most patients would not even be able to secure basic primary care services. However, we are also acutely aware that our 600 health centers are able to serve only one of every 5 people who need them nationally; and we are constantly frustrated when our patients need a level of care -- be it specialty or inpatient care -- the cost of which is beyond both their reach and ours. We, like most of our patients, are struggling to do what we can, often in the face of insurmountable odds. Believe me, they and we need all the help you can offer.

Thank you Mr. Chairman, I would be happy to answer any questions you or the Subcommittee members may have.

Chairman **Stark**. Thank you.

Dr. Anderson.

STATEMENT OF GAIL V. ANDERSON, JR., M.D., ASSOCIATE MEDICAL DIRECTOR, GRADY MEMORIAL HOSPITAL, ATLANTA, GA; ON BEHALF OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. **Anderson**. Thank you, Mr. Chairman.

Mr. Chairman, I am Dr. Gail V. Anderson, associate director of Grady Memorial Hospital, in Atlanta, GA, and director of the hospital's Surgical Emergency Clinic. I appear today on behalf of the American College of Emergency Physicians (ACEP), a medical specialty society representing over 14,500 emergency physicians. I am also accompanied today by Stephanie Kennan, an ACEP legislative representative.

We appreciate this opportunity to testify concerning the problems we face in emergency departments, as the economy has experienced a recession.

Grady Memorial Hospital is a public hospital. Both Emory University School of Medicine and Morehouse School of Medicine use our facilities for teaching residents and medical students. In Atlanta and across the country, public hospitals and their emergency departments, in particular, are the safety net for health care.

Emergency physicians meet the need for prompt treatment of patients, regardless of the patient's ability to pay, 24 hours a day. ACEP believes that quality emergency care is a fundamental right and should be available to all who seek it. Emergency departments are the only entities mandated by Federal law to provide care to all who need it, regardless of ability to pay.

However, the level of uncompensated care that our Nation has tolerated is being further exacerbated by those who have recently lost their jobs and cannot afford to purchase public health care insurance privately. Allowing this to happen forces emergency departments to provide more and more care, with fewer resources.

I want to stress clearly that a higher rate of uncompensated care threatens the ability of any citizen seeking emergency care, because as more emergency departments are forced to close or downgrade, there is an impact on the national phenomenon of ED or emergency department overcrowding.

Like emergency departments across the country, my ED is the provider of last resort, providing access to health are for those without public or private insurance protection. Even during the 1980's, ED's experienced higher rates of uncompensated care.

A study performed for ACEP by Mathematica, Inc., found that in 1986, nearly one-third of the care performed by emergency physicians was uncompensated. In 1989, my hospital provided outpatient care to 364,000 indigent patients, at a cost of over $38 million. In 1990, we estimate that my hospital treated 374,00 indigent patients, an increase of 10,000, at a cost of over $42 million.

The January 1991 report of the National Association of Public Hospitals shows Grady Memorial Hospital with the most emergency department visits, 261,000, and the most total outpatient visits, 854,000. While there was a decrease in inpatient admissions at

Grady last year, we saw a marked increase in the use of the emergency departments. Our visits have plateaued over the last several years, but they increased last year by 14,000. Most of the additional visits occurred in the last half of the year.

There are several reasons for this. At about the same the recession began to take hold, two other hospitals in Atlanta downgraded their emergency departments. For many hospitals, ED's are financial drains, because of the high uncompensated care patient load that comes through the ED doors. On a daily basis, I am seeing more patients who have no ability to pay for their necessary care.

For example, I recently treated a man who had worked in the restaurant industry in Florida, despite the partial loss of an arm, but he had lost his job. He came to Atlanta looking for work, but was still unemployed. He was living in a house with no heat or electricity and had been assaulted, when he came to the emergency department with head wounds.

After we treated him for his wounds, he remained for 2 days to recover, because we could not release him to an environment in which he could not recover, and social services could not place him. His case, sadly, is no longer unusual among the patients I treat.

My department treated another man who has fallen through the tracks, not only once, but twice. He came to Atlanta, looking for a job, after losing employment in Tennessee. he came to my emergency department for his health care. However, he continues to come to the emergency department, even after finding employment, because his employer does not provide health insurance until a probationary period is completed.

What makes the plight of the jobless and uninsured more difficult for the emergency department to withstand is that we continue to see increases in the number of working people who lack insurance. More people seeking care from the emergency department, without additional resources to pay for health care, creates overcrowding, which seriously jeopardizes the ability of any person, with or without insurance, to receive timely emergency care.

ED overcrowding occurs when patients who have been evaluated and stabilized are held in the emergency department, because they need additional care and there is lack of additional resources. Stays of 12 hours are commonplace, and stays of 24 hours or more are not unusual.

When an ED closes because it is overcrowded, ambulances must be diverted, slowing the ability of emergency patients to get care in a timely fashion. Overcrowding has been reported in at least 41 States and is now being studied by the GAO.

While solving the uncompensated care problem will not solve the ED overcrowding problem alone, it will go a long way to relieve some of the pressure we who serve in the emergency departments feel, as we try to treat our patients. Emergency physicians want to provide quality care, but ED's are not designed to provide the follow-up or continuous monitoring that some of our patients require.

Lack of action to stem the growing tide of uncompensated health care harms us all, through additional costs for health insurance, taxes, and, more importantly, in being able to receive the treatment we need in an emergency department. This is not the way to run a health care system.

ACEP believes that supporting access to emergency care, primary care services and initiatives to prevent illness and serious injuries before they reach the point where expensive emergency department care or hospitalization is necessary, are important and deserve congressional support.

In short, Mr. Chairman, the ED should not be the only source of health care for millions of Americans. ACEP urges this committee to take action and come to the rescue of those who have no health insurance, because of their employer's economic troubles.

Mr. Chairman, thank you. I will be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF GAIL V. ANDERSON, JR., M.D., ASSOCIATE MEDICAL DIRECTOR, GRADY MEMORIAL HOSPITAL, ATLANTA, GA., ON BEHALF OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Mr. Chairman, I am Dr. Gail V. Anderson, Jr., Associate Medical Director of Grady Memorial Hospital in Atlanta, Georgia, and Director of the hospital's Surgical Emergency Clinic. I appear today on behalf of the American College of Emergency Physicians (ACEP), a medical specialty organization representing over 14,500 emergency physicians across the country. We appreciate this opportunity to testify concerning access to health care and the problems we are facing in emergency departments (EDs) as the economy worsens.

Grady Memorial Hospital is a public hospital and the main teaching hospital for Emory University School of Medicine. In addition, Morehouse Medical School also uses our facilities for teaching their students. In Atlanta and across the country, public hospitals, and their emergency departments in particular, are becoming more and more the safety net for health care.

Emergency physicians meet the need for prompt treatment of patients regardless of a patient's ability to pay. ACEP believes that quality emergency care is a fundamental individual right and should be available to all who seek it. Emergency departments often serve as the entryway to the entire health system for uninsured patients, because alternative treatment sites may be in short supply or even unavailable in the community, or the patient cannot afford to visit a private physician. Thus, like emergency departments across the country, my emergency department is frequently the provider of last resort, providing some access to health care for those without public or private health insurance protection.

An increase in uncompensated care has dangerous ripple effects throughout our health care system, leading to hospitals closing or downgrading their EDs because of the financial drain, thereby reducing access to care for the poor and those without insurance; and contributing to ED overcrowding, which jeopardizes the delivery of prompt emergency care to every American with or without insurance.

THE UNINSURED AND EMERGENCY MEDICINE

Emergency physicians are among those who have to respond most directly to the problems of the uninsured. No other physician is available 24 hours a day for unscheduled care. In 1986, Congress mandated that every patient presenting to a hospital emergency department be given an appropriate screening examination. The goal of a screening examination is to determine whether the individual has an emergency medical condition, or a woman is in active labor. The law further requires that patients found to have emergency medical conditions or to be in active labor must be provided necessary medical treatment within the hospital's capability to stabilize their condition.

Therefore, emergency departments are the only entities mandated by federal law to provide care to all who need it. Patients come to our doors knowing they will receive care regardless of their ability to pay.

THE NATIONAL SCOPE OF THE PROBLEM

A 1984-1985 survey conducted by the National Opinion Research Center for the Health Care Financing Administration (HCFA) found that uninsured patients accounted for 19 percent of the visits to emergency physicians. Another survey conducted by Mathematica Policy Research, Inc., for ACEP in 1986 found that on average, 31 percent of the care provided by emergency physicians was uncompensated care . This rate was also higher in the Southern part of the United States.

INCREASE IN UNCOMPENSATED CARE

Even during the economic boom of the 1980's, EDs saw an increase in the demand for their services, and an increase in the number of those with no ability to pay for their health care needs. During the 1980's, uncompensated care at public hospitals climbed. By 1988, 29 percent of the all inpatient days at public hospitals and 52 percent of all outpatient visits were uncompensated. This level of uncompensated care cannot be sustained indefinitely and should not be tolerated. We should not accept an increase in the level of uncompensated care because of national economic hardship.

For example, at Grady Memorial Hospital we have five emergency areas treating over 250,000 patients per year. In 1989, we treated 259,234 patients in our EDs. In 1990, the number of ED visits had increased to 279,812. In the area in which I have responsibility, over the past three years we had plateaued at about 80,000 emergency department visits per year. However, in the last half of last year, beginning in the summer our volume increased by an additional 6,000 visits.

Grady Hospital also runs an ambulance service which serves one quadrant of our city. Grady is experiencing an increase in the use of our ambulance service. In 1989, Grady Hospital's ambulance service made 62,394 trips. In 1990, the same service made 70,622 trips. At the same time, Grady is seeing a decrease in patient admissions. In 1988, inpatient admissions were 48,232 patients; in 1990 only 45,235 patients were admitted. While the volume of inpatient admissions is decreasing, more people are using the ED to get their health care.

The cost of the indigent care Grady Hospital is providing is staggering. In 1989, Grady Hospital treated 364,054 patients who were indigent. In 1990, we estimate that figure to be 374,000 indigent patients. The value of that care in 1989 was $38,061,846. In 1990 the value of the care provided indigent patients with an estimated additional 10,000 indigent patients climbed to $42,636,000.

My ED is experiencing an increase in the volume of patients for several reasons. The worsening economy this past summer, along with decisions made by other hospitals, have shifted the care of those without insurance to my ED.

At about the same time the recession began to take hold, two other hospitals in Atlanta downgraded their EDs. For many hospitals, EDs are financial drains because of the high uncompensated care patient load that comes through the ED door. No one likes to close or downgrade their EDs, but for many it is a financial decision because they receive little or no public funding.

On a daily basis, I see patients who tell me they would have sought care earlier or at a different site but they lack health insurance. And since this summer, I have heard more stories of people who had insurance, but their firms have cut them back to part-time employment and they lost their insurance, or they lost their jobs altogether and cannot afford to purchase health insurance on their own. The patients I am now treating are saying more often that they delayed care because they did not have insurance, or that they would have gone to see a private physician, but did not because they could not afford to do so without insurance,

For example, last Friday I treated a man who had worked in the restaurant industry in Florida despite the partial loss of an arm, but had lost his job. He came to Atlanta looking for work, but had not yet found employment. He was living in a house with no heat or electricity. He had sold his jacket for $30 and was later assaulted. He came to the ED with head wounds. He obviously had no insurance, but he also had no real home to which he could be released. Social Services could not place him. He spent two days in the ED recovering from his wounds. His case is not unusual. I see an increasing number of patients who not only have no health insurance, but have become homeless when they lost their jobs.

This case illustrates several points. First, this man's lack of a job forced him to live in an environment that was not particularly good for his health. Second, when he needed care for his head wounds, he received it, but all of us will pay for that care through higher taxes, higher insurance premiums, and cost shifting. In addition, because he could not be returned to the house in which he was living, he contributed to a phenomenon emergency departments across the country are experiencing, ED overcrowding. I will discuss this later in my testimony.

My department treated another patient who has fallen through the cracks not once but twice. This patient lost his job in Tennessee and came to Atlanta looking for work. Without a job, he had no health insurance and could not afford to purchase private insurance on his own. He came to my ED for his health problems because he lacked insurance and had no other health provider. He has now found a job, but still must come to the ED for his health care needs, because his new job does not provide insurance until he has cleared a probationary period.

What makes the plight of the jobless uninsured more difficult for the ED to withstand is that we also continue to see increases in the number of working people who lack insurance. For example, on Monday, I treated a 35 year old woman for a broken wrist. She had delayed seeking care for a week because she did not have insurance. She mentioned to me that in other jobs she had had insurance, but the roofing company she was now working for could not afford to purchase insurance for its employees. She came to my ED because she could not afford to go to a private orthopedist, where she would have preferred to be treated. She had no choice but to come to the ED after suffering from pain for a week.

I also recently treated another woman who lacked health insurance. She was able to receive care from a family physician for basic health needs. However, she required a more extensive evaluation and possible surgery. She sought help in the ED because she had no other place to go for her care without insurance.

To give you just one more example of the kinds of difficult decisions the patients I see must make, I would like to mention the case of a 31 year old male construction worker who had sole custody of his five month old daughter. The child's mother was a cocaine addict. He had no health insurance through his job. He was able to qualify for AFDC benefits and Medicaid. He then faced the dilemma of earning more than was allowed by law in order to be able to retain his benefits. What he really wanted was to be able to earn enough to enable him to purchase private insurance, which would have allowed him to see the doctor of his choice.

EMERGENCY DEPARTMENT OVERCROWDING

This leads to the additional issue of emergency department overcrowding. ED overcrowding is the holding of patients in the ED once they are evaluated and stabilized because they need additional care or there is a lack of additional health resources available. Stays of 12 hours are commonplace and stays of 24 hours or more are not unusual. Such overcrowding of the ED at a time when more patients are seeking care in the ED jeopardizes the ability of emergency department staff to provide timely emergency care to those who need it.

To put it bluntly, when ED overcrowding occurs, it jeopardizes the delivery of timely emergency care to each and every one of the patients seeking care in the ED whether they have insurance or not. When an ED has to close because it is overcrowded, ambulances must be diverted. This slows the ability of an emergency patient to get to an ED to be cared for in a timely fashion.

When I must hold a patient in my ED, we make every attempt to deliver quality care, but we are neither staffed nor designed to provide the ongoing continuous monitoring that patients need. In my ED there is no privacy for patients, bedpans serve as restrooms, and visits are severely limited. Every day, I send patients home that I would rather keep in the hospital or whose entire hospital stay is spent in the ED, which was never designed to provide the basic amenities like a quiet restful area in which to recuperate, that most of us think of when we think of a hospital stay. ED overcrowding is not limited to large cities in the Northeast corridor. Nor is it limited to public hospitals which care for the poor and uninsured. Many of our nation's private hospitals are now experiencing problems as severe as those confronting public hospitals.

CAUSES OF ED OVERCROWDING

In the boom of the 1980's, no one could have predicted the impact of drug abuse and AIDS on our nation's acute care hospitals. Few thought that our haphazard system of health care programs for the poor, the elderly, and the uninsured would come apart so quickly as health care costs escalated and we attempted to reduce the federal deficit. Few understood that this meant that for millions, the ED would become their sole source of medical care. In addition, efforts to foster health care competition has encouraged hospitals to convert medical/surgical beds to more financially positive programs such as alcohol and drug treatment units.

Many hospitals have chosen to opt out of the business of providing trauma care entirely, because it was costly and expensive care, and many of the patients did not have insurance. In addition to these problems, the nursing shortage has meant that hospitals do not have a sufficient number of the nurses to provide inpatient care.

THE NATIONAL SCOPE OF THE PROBLEM

In 1989, ACEP conducted a survey of its 54 chapters to help assess the extent of emergency department overcrowding, which had initially been reported in New York City, Boston and Los Angeles. Our chapter survey showed that 41 states reported overcrowding problems. While solving the problem of the uninsured would not completely solve the problem of ED overcrowding, it would go a long way in assisting the already tightly stretched safety net of the ED.

ACEP believes that supporting access to primary care services and initiatives to prevent illnesses and serious injuries in individuals before they reach the point where expensive emergency department care or hospitalization is necessary are important initiatives deserving Congressional support.

CONCLUSION

Emergency Physicians care for all who come seeking our services regardless of their ability to pay. We serve on the frontlines of caring for those individuals who have somehow fallen through the cracks of our society and we want to give the best care possible to our patients. Yet as a nation, we have tolerated an increasingly high rate of uncompensated care and asked that the safety net, the ED, provide more and more care at the same time there are fewer and fewer resources to provide that care. Lack of action jeopardizes the ability to care for any of our citizens. This is not the way to run a health care system.

While full scale reform of our nation's health care delivery system seems is being discussed, ACEP is concerned that Congress also take appropriate steps to stem the tide of the increasing numbers of individuals who have no access to health insurance because of their employer's economic troubles. The ED should not be the only source of health care. In order for there to be quality care, there must be timely care.

It also is important to stress that the more individuals seeking care in the ED, the more likely ED overcrowding will occur, jeopardizing the delivery of timely emergency care to all of us regardless of who we are and what kind of insurance we have or do not have.

Chairman **Stark**. Thank you.

Dr. McDermott.

Mr. **McDermott**. I will just take one short question.

Chairman **Stark**. Help yourself.

Mr. **McDermott**. There has been a proposal made that the community clinics could be used as the means by which we expand the coverage for those who are not presently covered. I understand that today there are about 6 million people in America in community clinics, at a cost of about $500 million, somewhere around $88 apiece.

If we were to take the 15 million who are not employed, let us say the number is 15 million, and gave you $88 per patient, would it be possible for you to deal with the health care needs of the unemployed on $88 a year?

Mr. **Bartkowski**. Well, I think that $88 is an average of differences in regions. I think that community health centers for 25 years have proven to be cost-effective in providing the greatest access to those people who usually cannot get care anywhere else.

There is a proposal by the National Association of Community Health Centers which you are talking about, and they are proposing expanding access by the year 2000 across the country, creating new community health centers and expanding other community health centers. I think an expansion of that community health care program would go a long way in removing some of the barriers that people have to get care. Whether we could do it on $88 versus $100, I think we have been shown to be the most cost-effective approach to providing access to care.

Mr. **McDermott**. Do you think it could be done, without being part of a major system overhaul?

Mr. **Bartkowski**. I think it needs to be part of a complete universal approach to providing access to care.

Mr. **McDermott**. Thank you, Mr. Chairman.

Chairman **Stark**. I just wanted to thank the witnesses. You have been preaching to the choir that the emergency room physicians, are overworked and for the wrong reasons. I rely on your sub-specialty to provide me with anecdote after anecdote of what happens when we do not have adequate care. Even if we do, we are still going to need Mr. Bartkowski's group, because, in addition to providing care for the poor, our community health centers provide an interface between those for whom the system is foreign, either because they have never had the money, or they are new to our country and our ways, or there is a major language barrier, or there is just a lack.

It would seem to me that somebody like myself could probably fill out those annual medical exam things in my sleep. But I would venture that somebody who has not had the luxury that I have enjoyed of physical examinations and good primary care would have a difficult time. I imagine it would take you in your clinic sometimes two or three times as long to work up a patient, as it would in an emergency room, where people understand the language and the procedures. So, we are going to need you, if we ever get around to providing the good care that Louisiana provides.

I just want to thank you for your help, each of your groups, in helping us try and find a solution. I will ask you one question: Are you all familiar with Dr. Sullivan's plan for solving the problem? Are you familiar with it, "the abstinence, celibacy, exercise, get along with your spouse" plan? Have you all heard that from the Secretary of Health and Human Services? Are there any of you who feel that plan has any chance of helping solve the problem of medical access or health and medical care delivery in this country?

Mr. RAMSEY. I would have to venture a guess that it probably will not totally solve the problem, yes, sir. [Laughter.]

Chairman STARK. How do you think it would sell in Louisiana, particularly the celibacy part? [Laughter.]

Mr. RAMSEY. I think there would be a great deal of laughter throughout the State.

Chairman STARK. I know, and the Republicans for some reason like that part of it, but we Democrats just——

Mr. RAMSEY. We have a Republican Governor now, so he may think that is a good idea, as well. [Laughter.]

Chairman STARK. I am sure that is why he switched.

Well, enough bashing. Thank you very, very much. You make a contribution to this, but, in particular, you are giving some of us the hope that we should go on and see if we can find a solution to this problem. Thanks a lot for being here with us today.

The subcommittee is adjourned.

[Whereupon, at 12:16 p.m., the hearing was adjourned.]

[Submissions for the record follows:]

Statement of Lisa M. Carroll,
Vice President of Health Services
Small Business Service Bureau, Inc.
Ways and Means Subcommittee on Health
Health Insurance for the Unemployed
March 21, 1991

Chairman Stark and Members of the Committee,

Thank you for the opportunity to present our views regarding health insurance for the unemployed. My name is Lisa M. Carroll. I am a registered nurse and Vice President of Health Services for the Small Business Service Bureau, Inc. (SBSB). SBSB is a national membership organization representing over 35,000 small businesses. SBSB provides legislative advocacy, management assistance and group benefits and services to small companies employing fewer than ten (10) people. One of the most vital services SBSB offers to small businesses is access to group health insurance through Blue Cross and Blue Shield and HMOs.

There was an estimated 37 million Americans without health insurance coverage in 1990. Nineteen percent of those uninsured are employed by small businesses. As more businesses fall prey to the recession, the unemployment rates increase as well as the number of individuals joining the ranks of the uninsured.

SBSB understands this problem and supports reasonable approaches to solving it. However, we do not support balancing the needs of the uninsured on the backs of the small business community. Neither does SBSB support pouring the large uninsured population into a federal program which will be unable to support the additional burden and possibly fail the community it was originally created to assist. Medicare was never intended to provide health insurance for the uninsured general population.

We need to keep the country's small businesses operational and allow them access to affordable health insurance for themselves, their dependents and employees.

If we allow the private sector to work by providing small businesses expanded access to private health insurance, two goals will be accomplished. The number of individuals without insurance will decrease and the number of companies remaining in business will increase, thereby reducing the number of unemployed.

Currently, 18% of the total monthly health premiums go to pay for mandated benefits. A recent study indicated that 16% of uninsured small businesses indicated they would purchase health insurance for their employees and dependents if there were no mandates which drive up costs. There are currently several states which have attempted to reform the small group market. Florida, Illinois, Kentucky, Missouri, Rhode Island, Virginia, and Washington all have passed laws allowing health insurance providers to offer "bare bones" policies to small companies unable to offer health insurance due to prohibitive costs. In addition Ohio, Massachusetts and New York are considering such legislation.

Currently, small businesses and/or self employed persons are not authorized to take a tax credit with the purchase of health insurance. Oregon has proposed a five year tax credit of 50% of the employer contribution for small companies who did not previously offer health benefits. New York has a proposal allowing for a tax credit against the franchise tax.

At present large corporations can deduct from their federal taxes 100% of their contribution to their employee's health insurance premiums. However, unincorporated small businesses can deduct only 25%, and that deduction expires in two years. SBSB encourages the Congress to allow not 25%, but 100% deductibility for small companies as well as large.

History shows that the state and federal governments are generally not effective at improving efficiency. The higher costs resulting from inefficiency will be shifted to those small employers struggling to survive in a recessionary economy. Transferring private sector responsibility to the government will create havoc for both sectors of the economy.

SBSB recognizes the terrible financial burden imposed by unemployment, as well as the devastation an illness can have on a family with no health insurance. Nationally recognized expert on economics, Dr. David Birch, indicates that companies with fewer than 20 employees created 88% of new jobs between 1981 and 1985.* To reverse the impact of the recession, the business climate must be conducive to allow this type of growth for 1991 to 1995. The government must provide tax credits, allow full deductibility of health insurance premiums, and provide relief from over 800 state mandated benefits to allow America's small businesses to compete freely in our expanding and evermore competitive global marketplace.

Thank you.

*Birch D.L.: The Invisible Hand, Job Creation in America. Collier-MacMillan, New York, 1987; pg.16.

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STATEMENT OF GOVERNOR BOOTH GARDNER
HEALTH BENEFITS FOR UNEMPLOYED WORKERS
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
MARCH 21, 1991

Mr. Chairman, members of the committee, I appreciate your attention to a major gap in our health care system. It is unfortunate and sometimes tragic that when an individual loses a job, the health coverage that came with that job is also gone.

Many people in the State of Washington face a tough challenge. The need to protect old growth forests is forcing many communities to change their traditional economy. Skilled jobs associated with the timber industry may never return.

Unfortunately, jobs are not the only thing at risk. Many of these rural communities have limited resources to respond to this great stress.

Not only will many people lose jobs, but many families will find themselves at risk for more health problems and no financial protection from medical bills. Hospitals and doctors in many of these communities will have a difficult time making ends meet.

The COBRA extension is simply not an option for many of the people in these communities. Also, we need to look to a broader, more inclusive and more equitable way to keep the working people in our communities in the health care system.

I appreciate your attention to the problem of health benefits for these people. As our state wrestles with health care reform, this issue will be a part of our discussion as well.

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